

This document presents suggested survey and planning procedures in keeping with the major principles proposed in PHS Publication No. 855, "Areawide Planning for Hospitals and Related Health Facilities."

HOSPITAL AND MEDICAL FACILITIES SERIES
(Under the Hill-Norton Program)

community
planning

Procedures for

AREAWIDE HEALTH FACILITY PLANNING

A GUIDE for Planning Agencies

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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Foreword

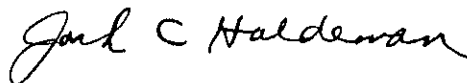
This manual amplifies the recommendations on planning techniques presented in "Areawide Planning for Hospitals and Related Health Facilities," report of the Joint Committee of the American Hospital Association and the Public Health Service. The report dealt with the broad aspects of planning by local health facility planning agencies. The details of planning were left to this manual, which is addressed primarily to executives and directors of new areawide planning groups and to persons interested in establishing such organizations.

The techniques suggested are based upon experience gained in a number of cities. While the proposed methodology is believed to be quite flexible, users of the manual should feel free to experiment and modify the suggested material to suit local conditions.

Planning is a continuing process. Good planning requires that officials of planning organizations be ever alert to new trends and developments. It also demands that they continually seek to obtain a deeper understanding of forces influencing the need and demand for hospitals and related health facilities. Therefore, while this manual emphasizes the initial phases of the planning process, it also devotes attention to periodic data-reporting and suggests problem areas which should receive detailed study once a planning program has become well-established.

This document suggests activities through which local planning agencies can develop policies and procedures for guiding the future development of hospitals and related health facilities within specific geographic areas. It is hoped that the manual will materially assist officials of these organizations to effectively stimulate the most judicious development of health facilities and the provision of needed facilities and services.

The Public Health Service would like to express its appreciation to those organizations which reviewed the initial draft of this document. These include the Massachusetts and Maryland State Hill-Burton agencies, and the local planning associations in Chicago, Pittsburgh, and Kansas City. The staff is also indebted to many other individuals and organizations for their helpful comments. Among these are suggestions made during the course of a series of working conferences on the methodology of areawide health facility planning, conducted by the Public Health Service and the American Hospital Association to review the procedures contained in the preliminary draft manual. The following persons were primarily responsible for preparing the material for publication: Kenneth Baum, public health advisor; Anita Reichert, technical writer; and John D. Thewlis, chief, Operations Branch.



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Chapter I

Organizing For Planning

BACKGROUND

The Need for Better Planning

The need for improved coordination of health facilities and services in the United States has long been recognized. As early as 1947, the Commission on Hospital Care noted that groups of hospitals working together can materially improve their services and maintain higher standards of care (1).

Both this Commission and the later Commission on Financing Hospital Care made strong pleas for cooperation among hospitals (2). Both bodies recommended a careful study of total community needs prior to building new hospitals or expanding or replacing existing institutions. In addition, both urged the sharing and integration of specialized services among various hospitals.

More recently, the need for better planning has been accentuated by public discussion of the rapidly increasing cost of hospital care as well as criticism of unnecessary duplication and improper utilization of services and facilities. The importance of planning has also been emphasized by the growing obsolescence of many older facilities.

The Regional Conferences

During the spring of 1959, the Public Health Service and the American Hospital Association jointly sponsored four regional conferences to explore ways of improving health facility planning (3). These were attended by several hundred persons interested in hospitals and health. A major conclusion of the conferences was that

hospitals should serve as focal points for community health services in a coordinated system developed under the guidance of an areawide planning agency with a paid professional staff.

The Joint Committee

Following the regional conferences, the Public Health Service and the American Hospital Association established a Joint Committee to develop guidelines for carrying out the conference recommendations. The Committee, composed of 15 outstanding leaders in the hospital, medical, and health fields, was requested to develop principles for organizing local planning agencies, to define their functions, and to outline planning techniques.

In its report "Areawide Planning for Hospitals and Related Health Facilities," (4) the Committee indicated that areawide planning is both desirable and possible, that it should be a continuing process and that, if properly executed, it will help to assure that future expenditures for construction, expansion, renovation and replacement of hospitals and related facilities will be made in response to established need. The Committee summarized its conclusions by noting that areawide planning will aid communities in:

- ♦ Maintaining and improving quality of care as economically as possible;
- ♦ Correcting deficiencies in existing facilities and services;
- ♦ Stimulating the construction of needed facilities, including those for education and training;

- ♦ Discouraging construction not conforming to community needs;
- ♦ Assuring more effective use of community funds by avoiding unnecessary duplication of highly specialized, infrequently used, expensive facilities;
- ♦ Improving patient care by developing more effective interrelationships among facilities;
- ♦ Developing an orderly distribution of all facilities in keeping with the projected population characteristics and overall community development;
- ♦ Encouraging individual facilities to define and carry out their objectives and projected roles in relation to other facilities, services and community needs;
- ♦ Stimulating facilities to recognize opportunities for better coordination of services;
- ♦ Demonstrating the need for philanthropic and public funds through a well-developed information program.

Definition

Specifically, areawide planning involves the establishment of local health facility planning agencies, each governed by a broadly representative group of lay and professional community leaders.* These organizations are vehicles for achieving greater local participation in planning and developing adequate facilities and services. They also provide a mechanism for coordinating the construction plans of individual institutions and for guiding facilities in planning their own future development in relation to recognized community needs.

The Hospital Council of Greater New York, formed in the midthirties, was the first local planning organization. It was followed in 1946 by the Columbus Hospital Federation. Since then, local planning groups have been established in Detroit, Kansas City, Chicago, Pittsburgh, and elsewhere.

THE ORGANIZATIONAL STAGE

The organizing process involves creating a climate for planning, determining the objectives of the proposed planning group, drafting a constitution and bylaws, recruiting community leaders to serve on the governing board, securing adequate financing to support the organization's activities, and recruiting a staff.

One or more influential and dedicated persons must take the lead in working toward the organization of a local planning agency.

The stimulus for forming a local planning agency can come from a variety of sources. In some cases it has been provided by business leaders; in others, a hospital association or a unit of State Government has served as the catalyst. But, no matter where the idea germinates, experience has shown that the services of some respected, energetic, and enthusiastic person or persons are needed to organize a local planning group.

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or during the initial areawide planning to

create community interest and to secure the endorsement of influential organizations and groups concerned with health problems.

State Advisory Councils

In each State there is a council set up to advise Hill-Burton officials on the conduct of the program within the State. These councils include representatives of hospitals and other facilities, the medical profession, and the public.

State advisory hospital councils can be instrumental in helping to develop support for the formation of voluntary planning agencies by declaring support for areawide planning in general and by endorsing particular planning efforts within the State. The Federal Hospital Council, which is a national advisory body established pursuant to the Hill-Burton legislation, has already recommended

*Throughout this publication, the terms "planning group," "planning agency," "planning organization," and "planning council" are used interchangeably to designate such an agency. Whether used alone or modified by the words "local," "areawide," or "voluntary," these terms refer to the local health facility planning agency established to carry out areawide planning functions as defined above.

to the Surgeon General of the Public Health Service that greater emphasis be given to areawide hospital planning.

Hospital and Nursing Home Associations

Endorsement of the areawide planning concept by hospital and nursing home associations should be sought even before formal organizational work begins. Since planning involves working intimately with facilities, their active support is essential. Close cooperation between the organizers and appropriate associations will emphasize the fact that planning is a joint effort by facilities and planners to find solutions to difficult problems. The cooperation of individual administrators and facilities will be easier to enlist at later stages if the helpful nature of planning is emphasized at the outset.

Hospital and nursing home associations should be encouraged to establish administrators' committees to advise the sponsors of the prospective planning group during the organizational stage. At a later time, such committees can serve as appropriate vehicles for communication between the associations and planning officials.

Associations should also be consulted on the best way they and the facilities which they represent can be given a voice in the planning effort.

Medical Societies

Endorsement of the planning effort should also be sought from State and local medical societies while the planning group is still in the formative stage.

Physicians use hospitals frequently and influence the volume of hospital services required by determining the persons to be admitted and the date of discharge. Their expressed needs provide the most tangible evidence of demand for hospitals and related facilities.

Health facility planning does not consist exclusively of promoting or discouraging construction projects. It goes beyond this and deals with the deeper factors which create the pressures for construction. Sometimes these pressures can be relieved by providing suitable alternatives to expensive general hospital care, or by developing programs which serve as alternatives to institutionalization. For example, neighboring hospitals have, in some instances, reduced a bed shortage in one and increased occupancy in the other by arranging for reciprocal medical staff privileges.

There is also increasing evidence of the efficacy of utilization committees in promoting judicious and appropriate use of hospitals.

Educating physicians to the possible advantages of seeking alternatives which minimize the need for additional construction, especially of general hospital beds, requires close cooperation and liaison between planning officials and the medical profession. Therefore, planning officials should build close working relationships with physicians from the earliest planning stage.

Business Leadership

The support and understanding of the top echelons of the business community are also essential to creating an atmosphere in which successful planning is possible. It is to this group that a planning agency must eventually turn for the majority of its board membership if it is to avoid the appearance of being dominated by professional vested-interest groups.

In addition, participation of top business leaders is needed to create support for a planning program once it is initiated. The business community commands respect, and its ability to mobilize financial resources is useful in encouraging the participation of facilities and their cooperation with the planning program.

Wherever possible, it is desirable that top businessmen rather than health professionals take the lead in organizing local planning groups. Doors are open to business leaders, enabling them to sell the planning idea where it counts.

Other Interested Groups

The nature and purposes of the prospective planning program should also be discussed with offices for the aging, welfare departments, health and welfare councils, licensing agencies, and the like. Wherever possible, endorsements should be obtained from these and similar organizations.

The organizers of a local planning group should determine the objectives of the organization, the relative importance of its various functions, and the phasing of various activities into its program.

Prior to forming a local planning group, the organizers have to make some basic decisions about its objectives and activities. Will it emphasize research? Should it be a vehicle for fund-

raising? How extensively should it engage in consultation? Will it concentrate on controlling construction? Should it function primarily as a public information medium? These are some of the questions that have to be answered. The decisions on these points will condition the nature of a planning organization's board and committee structure, as well as the kind of professional staff that it ought to employ.

The organizers should recognize that initially the council's most important job is to sell the planning concept. Activities of the group should be focused on this goal rather than diverted into interesting, but extraneous, channels.

Research

All planning groups will need to engage in fact-finding or "applied" research which tends to be descriptive; helps to locate and define problems and clarify issues; and serves as a basis for forming judgments. "Basic" research which examines questions of a theoretical nature and attempts to develop widely generalizable conclusions should be avoided, at least during a planning group's initial years of operation. Preoccupation with this type of research can undermine a planning program by giving the agency an appearance of detachment from reality. It can also divert the attention and energies of its professional staff from concentrating on more immediate and practical problems.

Fundraising

If fundraising activities are to be undertaken at all, they should not be initiated until the agency

has been operating for a number of years and has an accepted and going program. Joint fundraising campaigns have by no means been universally successful, and any attempt to couple this type of activity with a planning program should be viewed with extreme caution. In any case, fundraising should never be undertaken in the absence of experienced staff or appropriate professional counsel.

Consulting Functions

Another question with which the organizers will have to deal is the extent to which an agency should serve as a consultant and advisor to individual facilities. While consultation will be a normal part of the process of guiding and influencing individual institutions, the extent to which such consultation can be provided will depend on the availability of staff and the number of facilities in the particular planning region. While agencies in smaller regions can devote more time to individual counseling, they should avoid becoming, in effect, nonprofit consulting firms.

Planning agencies will usually wish to provide the kind of advice which gives individual facilities a look at overall needs and helps them to see how they can best fit into the total community picture. For more specific advice on the details of its own future development within the framework of overall needs, however, each facility should be encouraged to employ a professional consultant to work with its trustees and administrative staff.

DRAFTING A CONSTITUTION

Independence

While planning activities in a number of cities have been established within the organizational framework of a hospital association or a health and welfare council, a planning agency should preferably be an independent organization. Independence avoids formal association with vested interests and preserves the group's objectivity in the public mind. It removes any question of the organization's ability to report directly to the

public without interference, and it helps the planning group to build rapport with facilities irrespective of existing organizational ties.

Sequence of Events

The organizers may proceed with the formal establishment of a planning group in a number of ways. They may choose to draw up a constitution, or corporate charter, and subsequently select the initial board of directors, or they may first

select prospective directors and work with them in drafting the constitution and formally establishing the agency. In a few instances, formal organization has followed a comprehensive survey of health facility needs sponsored by a committee of leading citizens.

The organizers customarily serve on the initial board of directors. Where the organizing group is small, however, it is advisable for them to appoint additional board members to provide broad and adequate public representation.

The constitution of a voluntary local planning agency should be drafted with the aid of experienced legal counsel. It should contain provisions that will assure granting of nonprofit status.

Legal counsel should be secured to assist in drafting an agency's charter, or constitution. The lawyer or legal firm chosen to advise the organizing group should preferably have previous experience in helping nonprofit organizations to qualify for tax exemption. Appropriate legal advice will help to prevent difficulties in obtaining tax exempt status and will assure compliance with all applicable Federal, State, and local statutes.

Tax Exemption

The Internal Revenue Service will carefully scrutinize the group's organizing documents and its manner or proposed manner of operations in determining whether it is entitled to tax exemption for Federal income tax purposes. Every voluntary health facility planning agency should

qualify under the appropriate provisions of Section 501(c)(3) of the Internal Revenue Code which defines an exempt organization as follows:

"Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, . . . literary, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of any candidate for public office." (26 U.S.C.A., § 501.)

All applicable wording of Section 501(c)(3) should be included verbatim in the agency's organizing documents.

Contributions to organizations exempt from taxes under this section are generally tax deductible under Section 170 of the Code.

Provisions of the Constitution

The constitution of a local planning agency should (1) state the organization's name, objectives, location, and area of jurisdiction; (2) provide for the group's perpetual existence; (3) establish a board of directors empowered to make and alter the organization's bylaws; (4) prescribe the manner of appointment of the initial board of directors; (5) provide for the disposal of assets in the event that the organization is ever dissolved; and (6) prohibit the use or disposal of the agency's funds or other assets in a manner inconsistent with its nonprofit status.

ORGANIZATIONAL STRUCTURE

The board of directors should be composed of top lay and professional community leaders, a majority of whom are selected to represent the public.

The board of directors should be limited to a reasonable and manageable size to prevent its becoming unwieldy as a policy-making mechanism. To keep the size of the board within bounds, no attempt should be made to provide representation for every possible interested group. Interested parties can best be given a voice in the planning agency's activities through membership on advisory committees.

Executive Committee

The bylaws of the planning agency should provide for the establishment of an executive committee to act for the board of directors during intervals between board meetings. Usually this committee will include the board chairman and other officers plus one or two additional board members.

The executive committee should be authorized to exercise all powers of the board except the power to adopt, amend, or repeal the bylaws. Actions of the executive committee should be subject to review by the full board. Minutes of

executive committee meetings should be promptly forwarded to all directors.

Selecting the Membership

One method of selecting board members would be to solicit nominations from business and labor organizations, leading local citizens, elected public officials, and community agencies concerned with health and welfare.

Some planning agencies may wish to establish ex-officio positions on their governing bodies for certain government officials and executives of professional organizations.

Qualifications of Members

Board members should have sufficient stature in the community to enhance and, perhaps, to assure acceptance of the planning agency's recommendations.

While full-time professionals in the hospital and health fields may be included on the governing body, a majority of board members should be appointed to represent the public. Board members should be appointed because they are top community leaders and not necessarily because of any associations with hospitals or health. A board composed predominantly of influential community leaders will help to avoid the impression that the planning agency is dominated by vested interests.

Selecting public representatives for places on the board is complicated by the fact that many top community leaders are also hospital trustees. A person serving as a trustee should not be disqualified ipso facto from being appointed to the agency's board to represent the public. A trustee selected as a public member, however, should be a broad-gauge individual who will speak for the community rather than for a particular facility.

An agency's bylaws should provide that the term of some fraction of board members will expire annually. The number of times that a board member may be reelected should also be specified.

The governing board of a voluntary planning agency should not be self-perpetuating. Directors should be required to step down after a specified number of terms to make way for new members. In order to provide continuity of leadership,

however, the terms of all directors should not expire simultaneously. The retention of some experienced members will thus be assured.

The expiration of the terms of office of the initial board members can be staggered by dividing them into several classes, each with terms expiring at a different time. When this device is employed, the membership of each class is usually determined by lot.

Technical advisory committees should be established to provide the board of directors with adequate professional guidance.

Appropriate committees should be established to guide the board of directors on matters requiring professional judgment. Committee members should be chosen primarily on the basis of professional knowledge and status. A majority of the members of each advisory committee should be drawn from outside the ranks of the board, but at least one board member should serve on each committee. In this way, some board member will always be familiar with a particular committee's deliberations and prepared to interpret its professional judgments to his colleagues.

The executive director of the planning agency should also be a member ex officio of all advisory committees. Either he or the appropriate committee chairman should insure that advisory committee recommendations are presented to the agency's board of directors for necessary action.

Types of Advisory Committees

Some of the more important types of technical advisory committees that should be considered for establishment are discussed below; however, the exact nature of the committee structure and the types of committees to be formed are matters for local decision. Technical advisory committees should be formed only when they can make a real contribution to the planning effort.

Planning committee.—A planning committee can review need estimates developed by the agency's staff. It can initiate surveys and special studies. Other useful functions which such a committee can perform are: review of proposed guidelines for health facility development, expansion, and modernization within the region; and liaison with other planning activities within the region and with other health facility planning groups.

Financing committee.—A financing committee should help the planning agency to assess financial

resources available for health facility construction and advise it on methods of developing new sources of funds to meet construction needs. This type of committee might also be used to advise the planning agency on methods of financing its operating budget. Some agencies, however, will wish to leave this function exclusively in the hands of the board of directors.

Other committees.—A planning agency may wish

to evaluate the desirability of establishing advisory bodies through which liaison can be maintained with the medical and nursing professions. Other possibly useful advisory committees might deal with education and training, financing indigent care, paramedical and technical personnel, hospital architecture, research, and related matters affecting the need and demand for hospitals and related health facilities.

STAFFING THE PLANNING AGENCY

A planning agency's staff requirements will depend on the nature and extent of its operating program.

Most local planning organizations have begun with a skeleton staff consisting of the executive director and a secretary. As the planning program begins to take shape, additional personnel can be added as needed. The board of a newly organized planning agency may wish to consider borrowing a staff person from a state or local hospital association on a temporary basis to help in recruiting an executive director and to perform other interim duties. Although sometimes necessary as an initial step, such sharing of staff should not be considered a permanent arrangement.

Staff Specialization

The size and degree of specialization of a planning agency's staff will depend largely on the scope of the organization's activities. A planning agency which expects to provide extensive consultation to individual facilities will require a considerably larger staff than one which confines its activities to estimating needs and examining the merits of particular construction proposals.

The executive director of a voluntary planning agency should be selected primarily on the basis of leadership ability and organizational skills.

Imagination and leadership ability are the most important qualifications for a planning agency's director. He should be capable of working with

diverse interest groups and be able to develop an intimate knowledge of the community's "power structure." He should be familiar with the hospital field and conversant with hospital problems. Experience in community organization and planning is also desirable. While previous experience specifically in health facility planning would be a definite advantage, it is not absolutely essential.

When necessary, the new planning agency director can turn to a number of organizations for guidance in developing a planning program. These include existing local planning agencies, State Hill-Burton agencies, the American Hospital Association, and the Public Health Service.

A statistical analyst employed by a planning agency should be selected on the basis of skill in developing and interpreting hospital data.

Most planning agencies will wish to employ a person with a background in the field of hospital statistics, although smaller agencies may find it more convenient and economical to borrow statistical personnel from universities, Blue Cross, or other organizations. In selecting a person for a statistical position, the agency should regard knowledge of programing and data processing techniques as a secondary consideration. While helpful to a person in this position, data processing knowledge is not absolutely essential, especially since data processing can usually best be done by contracting with a commercial firm or Blue Cross. A statistical analyst employed by a local planning agency should, therefore, be chosen primarily for insight and skill in developing, presenting, and interpreting health facility data.

Architectural and engineering consultation and services are essential in the planning process.

Architectural and engineering services will be needed by the planning organization at the time it initiates a program for evaluating the physical and functional adequacy of existing facilities. Usually this type of evaluation should not be undertaken until the agency has been operating for a year or more.

Experience indicates that architectural and engineering services may be obtained in several

ways. Some planning councils retain full-time paid architects and engineers for this service. Others have been successful in employing retired architects and engineers for the period of time necessary to carry out this important work. Still other councils have engaged private architectural firms to conduct the evaluation. Whatever method is used, it is essential that the architects and engineers be knowledgeable in hospital planning and that continuity and uniformity be maintained. If established, an architectural advisory committee should be utilized to provide periodic consultation and advice as necessary.

FINANCING THE PLANNING AGENCY

Voluntary planning agencies should look primarily to industry, labor, prepayment plans, foundations, and private philanthropy as sources of continuing financial support.

Every planning agency will be faced with the problem of developing adequate sources of local financial support for its operating program on a continuing basis. Experience indicates that industrial contributors will probably provide a substantial proportion of the financial backing for voluntary planning agencies. Blue Cross and Blue Shield plans are also possible sources of funds, and may be willing to contribute staff services. Other possible sources of financing include charitable foundations, medical societies, labor organizations, and hospital and related health facilities.

Contributors should not be permitted to influence agency decisions.

Contributions to a planning agency should not give the donor a right to dictate or veto decisions of its board of directors. To preserve the board's independence, the agency's funds should not be provided predominantly or exclusively by hospitals and related health facilities.

Federal Grants

Federal demonstration grants available under the Hill-Burton program form another possible source of funds for areawide planning activities. The two types available are "seed" grants and grants to established planning agencies.

Seed grants are awarded to State Hill-Burton agencies, hospital associations, prepayment plans, or other appropriate nonprofit groups to provide necessary financial support for stimulating interest in areawide planning and organizing areawide planning councils.

Grants to established planning groups are usually made for one or more of the following purposes:

1. To provide financial support for the initial years of operating newly organized local planning agencies.
2. To assist established areawide planning groups to expand the scope of their activities.
3. To assist established areawide planning groups to expand their areas of jurisdiction.

Application forms and additional information about demonstration grants for areawide planning can be obtained by writing to the Division of Hospital and Medical Facilities, Public Health Service, U.S. Department of Health, Education, and Welfare, Washington 25, D.C.

GEOGRAPHIC AREA SERVED

The planning region served by a local planning agency should be logically and clearly defined. In some cases, the planning region should contain territory in more than one State.

Each areawide planning agency should clearly define the population and geographic area encompassed within its planning program. Initially, planning officials will usually have to delineate an agency's area of service on the basis of judgment and "feel" of the local situation. In doing this, they should consult with the appropriate State Hill-Burton officials. If necessary, the boundaries of the planning region can be modified at a later time.

In delineating an agency's planning region, its staff should take into account the economic and political cohesiveness of the population and of local health facilities. Wherever possible, planning agencies working in metropolitan areas should try to include the entire Standard Metropolitan Statistical Area as defined by the Bureau of the Budget.

The planning region of a local agency working in an interstate area should include appropriate portions of each State. Care should be exercised to insure that neighboring local planning regions do not overlap.

Chapter II

Beginning To Function

DEVELOPING PLANNING PRINCIPLES

Broad principles and policies to govern construction should be adopted by an agency's board of directors.

Planning agencies should immediately begin to develop principles and policies that will help in evaluating specific construction proposals and assist the staff in working with individual facilities. Such principles should be designed to promote the establishment of necessary service programs and to encourage improvement in existing facilities and the construction of needed facilities.

Naturally, the specific principles adopted will depend on the kinds of facilities a particular planning group is trying to encourage. For instance, while a planning organization in a large metropolitan region will generally wish to promote large, comprehensive hospitals, an agency planning for a predominantly rural area may be expected to adopt policies fostering development of high quality, accredited, but smaller and less extensive facilities.

In order to evaluate early project proposals, initial policies should be adopted soon after an agency is formed.

The adoption of initial planning principles to aid the agency's board and staff does not have to await the collection and analysis of detailed data. Goals and principles adopted initially, however, will usually have to be fairly broad and general. As adequate data become available and as need estimates are developed, more definitive principles can and should be adopted.

Dealing With Initial Construction Proposals

When a new planning agency is established, some construction programs will already be under-

way or in an advanced stage of development. Consequently, new planning agencies will usually be called upon to evaluate construction proposals soon after being established and before they have had sufficient time to collect data and establish long-term goals. Thus, the development of interim, initial criteria or planning principles will be necessary. These principles should be broad, emphasizing those things a project sponsor should do prior to initiating actual construction.

For example, the principles adopted should be addressed to questions such as the following:

1. Will the facility be operated in the public interest?
2. Is it likely to qualify for accreditation by an appropriate group?
3. Has adequate consideration been given to staffing and financing?
4. Has the State Hill-Burton agency been consulted?
5. Have appropriate city, county, or regional planning commissions been consulted?
6. Have local health and welfare organizations been consulted?
7. Have other medical facilities which may be affected by the proposed project been consulted?
8. Have the construction plans of such other facilities been taken into account?
9. Has the project sponsor cooperated fully and freely with the areawide planning group?
10. Is the size of the proposed facility adequate to promote economical occupancy rates?
11. Does the range of proposed services appear to be adequate in relation to community resources and service programs?

ESTABLISHING A TARGET DATE

During the initial planning stage, it is important that selection be made of a target date which is a future year for which needs are calculated and for which planning goals are established. Thus, purpose and direction will be given to planning.

A target year should not be regarded as a point in time at which goals are achieved, needs are met, and planning stops. Instead, the target year is a time to pause, to evaluate performance, and to reassess needs. As the target year approaches, a new target date should be set and new goals established.

A target date of 5 to 8 years should be established as a basis for calculating needs and for setting planning goals.

The target date should be a year for which reliable population projections are available or can be conveniently developed. Population projections are estimates of future population based on

various assumptions about trends in births, deaths, and migration. They are frequently prepared by health departments on the basis of vital statistics, and by such groups as planning commissions, school boards, and chambers of commerce.

Because population projections tend to decrease in accuracy in proportion to the length of the projection period, the target date should be 5 to 8 years in the future and never more than 10. This period of time provides adequate leadtime for the development of specific construction programs. A relatively short-range projection period helps reduce the errors that would be introduced into longer-range planning as a result of such factors as scientific advances, changes in medical practice, and the broadening of prepayment coverage. The ease with which short-range goals can be modified in the light of changing circumstances is an additional advantage of a relatively short planning period.

WORKING WITH FACILITIES

The planning agency's staff should keep in touch with the real problems of hospitals and related institutions through formal and informal channels of communication.

A planning agency's effectiveness is measured by its ability to influence the programs and construction activities of individual institutions. Acceptance of its advice is conditioned in part by (1) confidence on the part of administrators and trustees in the ability, fairness, and impartiality of the agency; and (2) the practicality and workability of the agency's suggestions and proposals.

The establishment of these conditions requires the development of two-way communication between the planners and individual facilities. Such contacts enable the agency to work closely with facilities and to advise them on the ever-changing needs for beds, facilities, and programs. In addition, they provide a mechanism through which the agency can keep in touch with pres-

ures on individual facilities which may lead to proposals for expansion. Good communications also help the agency to gauge how receptive facilities may be to specific planning proposals.

Each hospital should be encouraged to establish a planning committee to serve as a point of contact with the planning group.

Planning groups should encourage each hospital to establish a planning committee to work with the agency's staff. The planning committee should be separate from any already existing committee within the hospital. Its membership should be balanced among representatives of (1) administration, (2) trustees, and (3) medical staff. The planning committee should be a working group and should be held to a reasonable size. Each clinical department need not necessarily be represented. To ensure impartiality, the committee's chairman should be a lay trustee.

Planning Committee Functions

The hospital's planning committee is the vehicle through which the planning council and the individual facility seek a meeting of minds. Its principal responsibility is to work out a future development plan for a facility in conjunction with areawide planners. It should outline in general terms a development program for the facility in the light of community needs.

The planning committee also serves as a mechanism through which the results of surveys and special studies by the areawide planning staff can be interpreted to individual institutions. It is useful to the individual facility, in turn, as a place where differences with the planning agency can be resolved, and also serves as a vehicle through which the facility can transmit its own conception of present and future needs to the planning agency.

Each facility's planning committee should attempt to define the facility's aims for the target year.

While some facilities will have well-thought-through master plans for their own future development, many will not have developed a long-range program. This void should be filled as soon as possible after the inception of a planning program. For this reason, each facility's planning committee should be encouraged to work with the areawide planning staff in evaluating the facility's role in the community and in devising future goals. As part of this process, each facility should develop a written statement describing its present program, as well as its future needs and objectives. The outline of a facility's future program should be addressed to such questions as (1) What population and geographic area does the facility serve now, and what would it like to serve in the future? (2) What kinds of patient care services would it like to provide? (3) What kinds of research and educational activities would it like to carry on? Wherever possible, rough diagrams of space allocations for future construction, plot plans, and other pertinent material should also be included.

The specific nature of the future goals outlined by a facility will, of course, be conditioned in part by its ability to staff and finance particular kinds of activities, but these should not be the only limiting factors. The planning agency should guide each facility's planning committee as it proceeds to outline the institution's prospective functions. The agency's staff should, wherever

necessary, call attention to proposed goals which appear to be inconsistent with community needs. Consideration should also be given to patient care programs which can be carried on more effectively or economically by other facilities or other community agencies.

Value of Individual Planning Goals

By encouraging facilities to formally state their future goals and to outline prospective programs, the planning agency helps to initiate long-range planning within each facility. In addition, this process helps administrators, trustees, and medical staff to understand the need for adequately considering overall community needs when developing construction programs. It provides planning officials with a forecast of construction activities which, in some cases, will alert them to proposed, but ill-advised, construction projects. It also helps them to call attention to needed programs and services that are perhaps being neglected or receiving too little emphasis. Finally, it provides the agency with a knowledge of each facility's plans and desires, which is extremely important if the planning organization is to prevent expensive and unnecessary duplication of services and facilities.

Written goals also provide a basis for evaluating the degree of obsolescence and the potentialities of existing physical plants. It should be recognized that, on the basis of such an evaluation, some facilities' initially conceived goals may have to be modified.

Areawide planning groups should encourage each hospital to establish a utilization committee.

One of the functions of a planning organization is the promotion of administrative devices that will minimize the need for additional inpatient facilities. These may take the form of out-of-hospital services such as home-care programs, expanded outpatient services, and broader public health and preventive measures. Or they may involve the establishment of a hospital utilization committee.

Role of the Utilization Committee

Utilization committees examine patient records to determine the propriety of admissions and length of stay from the standpoint of medical judgment and need. They are usually composed

of representatives of a hospital's medical staff. Wherever possible, it is also desirable that one or more physician members of a hospital's planning committee serve on the utilization committee as well.

The functions of a utilization committee are neither punitive nor regulatory, nor is the utilization committee a vehicle for conducting research into the precise extent of "appropriate" or "inappropriate" use of hospitals. Rather, the committee is a device which, through factfinding and educational activities, helps practicing physicians

to understand how their hospitalization practices affect the demand for inpatient facilities. By calling attention to questionable admissions and overlong stays, utilization committees can, perhaps, help to minimize the rate of use of inpatient facilities (i.e., patient days per unit of population). In this way, these committees may contribute to minimizing the demand for additional beds.

While planning agencies should assist hospitals in establishing utilization committees, they should not participate directly in committee activities or attempt to influence deliberations (5).

WORKING WITH GOVERNMENT AGENCIES

State Hill-Burton agencies and local planning agencies should collaborate closely. Cooperation is important even in areas which have little or no priority for obtaining Hill-Burton funds.

Under the Hill-Burton legislation, Federal funds are made available as grants or loans on a matching basis to nonprofit organizations and governmental units for the construction of hospitals and related medical facilities. The legislation requires that a single State agency be established in each State to administer the program. The State agency is responsible, among other things, for making an inventory of existing health facilities, surveying the need for additional facilities, and developing a State Plan reflecting such needs. State Hill-Burton Plans usually divide a State into "service areas" and base priority for Hill-Burton aid on the extent to which existing facilities and services meet the needs of each area.

Similarity of Interest between State and Local Groups

Both the State Hill-Burton agency and local planning groups have an interest in promoting good planning for health facility construction regardless of the source of capital funds. Both are responsible for encouraging sound planning by individual facilities and for insuring that independent construction programs are reasonably related to each other. Consequently, every new areawide planning organization should establish contact with the State Hill-Burton agency

at the very beginning of the planning effort. Such groups should confer with Hill-Burton officials and attempt to ascertain how a local council can best assist the State agency and how it can best ensure adequate, community-oriented planning for construction projects in which Federal funds are not involved.

Local planning groups should seek official recognition by the State Hill-Burton agency. Planning groups in interstate planning regions should seek the recognition of the Hill-Burton agency in each of the States involved.

Recognition by the State Hill-Burton agency should be sought by all local planning groups. Such recognition by a legally constituted State planning authority will assist the local group in establishing stature in the area it serves and should assure close working relationships between the agencies. For example, a local planning group can work with State officials in developing and improving the portion of the State Plan relating to the geographic region which it covers. It can also provide advice regarding approval or disapproval of applications for Hill-Burton funds from facilities within the local area.

Some States now require that, where a recognized local planning agency has been formed, applications for Hill-Burton assistance must first be submitted for consideration by the local group. Recognized local groups can also advise State agencies on the relative merits of particular construction proposals within the same service area.

State Hill-Burton agencies should extend official recognition only to areawide planning groups meeting qualifications set by the State.

While the makeup of a planning agency will vary from community to community, it is desirable that the agency be organized as nearly as possible in accordance with principles enunciated in the report, "Areawide Planning for Hospitals and Related Health Facilities." (4) Particular care should be exercised to insure that the local group has a competent staff, is qualified for tax exemption, is not controlled or dominated by any one or more professional groups, and that it has responsibility for developing a program for a logical planning region.

The staff of a local planning agency should understand how the Hill-Burton program works.

Initially, the staff of a newly organized areawide planning agency should become thoroughly familiar with the operations of the Hill-Burton program. Specifically, the local staff should understand how the State Hill-Burton agency determines needs and the basis on which service areas are delineated in the State Plan. Local planning officials should know what kinds of data are required for the State Plan, how these data are collected, and how they are employed. They should also become familiar with the mechanics of making an application for Hill-Burton funds and the technical details of how funds are allocated.

State and Local Cooperation

Once orientation with Hill-Burton is achieved, a whole range of mutually advantageous relationships can be developed between local planning councils and State Hill-Burton agencies. Among other things, local organizations will frequently be in a position to provide the State Hill-Burton agency with needed information. They can serve as advisers on the development of the State Plans and provide advice on the allocation of Federal funds to applicants within the local region.

Frequently, the data developed by local planning organizations through special studies and through their regular data collection programs will be especially useful to State Hill-Burton agencies. This is particularly true of patient origin information and studies of hospital obsolescence.

Local planning groups should become familiar with government-operated care and treatment programs, including programs for purchasing care from private and nonprofit facilities.

While State Hill-Burton agencies are the government units most obviously interested in hospital planning, other government agencies also have considerable interest. Federal, State, and local government are all involved in operating hospitals and purchasing care. Most State governments license hospitals, nursing homes, and related facilities. Some States have their own construction grant programs, and there are numerous programs for financing hospital construction through special districts and authorities as well as with county, municipal, and other forms of local governmental aid.

Initially, a local planning group's staff should become acquainted with the above-mentioned programs. A special effort should also be made to learn about State mental health programs, welfare programs, and programs for the care of the aging. The staff should also become familiar with licensing statutes and regulations. The State Hill-Burton agency can materially assist the local planning agency to develop liaison with other governmental organizations.

Local health facility planning officials should become familiar with the role and functions of other local planning bodies where these exist.

Many metropolitan areas have city, county, or regional planning commissions. These organizations estimate future population changes and plan for required municipal services such as streets, transportation, and sewage disposal. They also develop zoning regulations and propose legislation designed to influence patterns of metropolitan growth.

Local health facility planners should know the people in their own particular city, county, or regional planning department. They should learn what information such organizations can provide and should acquaint the city planners with the functions of the health facility planning group. At later planning stages, they should work closely with the local planning department to ensure that official local or regional development plans give appropriate consideration both to the needs of health facilities and to the need for health facilities.

Chapter III

Data Collection

A planning group should be the custodian of a large body of comprehensive health facility data. Significant tabulations should be compiled, interpreted, and reported to facilities regularly, and other information should be readily recoverable for use as needed in particular situations.

Possession of data gives the planning staff a basis for working with individual facilities to help them balance out their own needs and desires with the needs of the total region. Further, data collected by a planning group help to locate, define, and measure the extent of problems and provide a common base of knowledge to guide policy development. Tempered with intelligence, experience, and judgment, these data also help administrators, trustees, and planners to recognize available

courses of action and to make wise choices among alternatives.

In addition, data collection involves individual facilities directly in the planning process. Being noncontroversial, it gives planning officials and hospital officials a chance to know each other under favorable circumstances. It also serves as a training device for members of the planning staff (6).

Data collection usually takes place in three stages: (1) assembling existing data; (2) surveying all facilities; and (3) establishing mechanisms for periodic reporting of information on a regular, current, and uniform basis. As the planning program progresses, special studies may be required from time to time to supply needed data not otherwise available.

ASSEMBLING EXISTING DATA

As an initial step in planning, all pertinent and readily available data on facilities, physicians, and population should be assembled.

Readily available information on past trends in beds, services, programs, and occupancy frequently reveals conditions which can be cited in selling the need for coordinated planning to the community as well as to owners, administrators, and trustees of facilities. Recognition of these conditions also helps to establish broad goals for the planning effort. Some trends, such as the extent of prepayment coverage and changes in the organization of care, are important indicators of possible future demand for facilities.

Other Hospital and Medical Data

Certain existing data are needed to plan a survey and to present and evaluate the results. For example, names and addresses of facilities are needed before a survey can take place. Information on licensure, accreditation, size, and ownership of each facility is needed, among other things, to classify data in preparing statistical tabulations and to assist in evaluating specific project proposals. In addition, data consisting of each physician's principal office address, hospital staff appointments, specialty, type of practice, and educational qualifications are needed in tabulating and analyzing patterns of referral to hospitals.

Population and Related Data

Population estimates and projections are required for preparing estimates of future areawide needs, and information on zoning, transportation, and community development is useful in planning the distribution of facilities and services.

When assembling existing data, planning officials should ascertain the use for which they were originally intended and appraise their reliability.

Sometimes data collected for one purpose are entirely useless for another; therefore, when col-

lecting existing information, planning agencies should find out how it was obtained, what it means, and how it was intended to be used.

For example, before using a published inventory of hospital beds in a community, the agency staff should attempt to find out how the information was compiled. Are the figures based on a square-foot standard? If so, what standards were used? Do the figures reflect a physical count of beds? Are they based on unverified replies to questionnaires? When was the information compiled? The answers to such queries will furnish insight into the reliability and further usefulness of existing data.

SOURCES OF EXISTING DATA

Sources of existing data include published material, government agencies, prepayment plans, and other organizations.

A number of governmental and nongovernmental agencies and organizations routinely collect, analyze, and periodically publish data on health facilities. All such sources should be explored by the local planning agency as a means of determining the additional data to be collected and guarding against the collection of information already available on a routine basis.

State Hill-Burton Agencies

In addition to advice and consultation, State Hill-Burton agencies should be able to provide considerable statistical information. State Hill-Burton Plans governing use of Federal funds for hospital and medical facility construction will ordinarily be available for inspection at State agency offices. Some States may have extra copies of the State Plan which they can furnish to local planning agencies.

State Hill-Burton Plans include an inventory of facilities showing for each the number of suitable and unsuitable beds, the annual numbers of patient days, and the average annual occupancy rate. They also contain maps of service areas, estimates of bed needs, and a listing of the relative need of each area within the State.

State Hill-Burton agencies collect data for inclusion in the State Plan which, in some cases, may be used by new local planning agencies as

an immediately available source of information on health facilities. Figures compiled from past State Hill-Burton Plans should also prove to be a principal source of trend data.

In addition to providing statistical information, examination of the State Plan and contact with State Hill-Burton officials will give a planning agency staff an opportunity to become familiar with policies governing Hill-Burton grants within the State.

State Licensing Agencies

Agencies of State government which license hospitals and related health facilities should also be requested to furnish necessary information. All planners should be familiar with State licensing laws and regulations. In addition to copies of these, State licensing agencies may also be able to supply information on each facility's classification and type of license.

In many States, the State Hill-Burton agency is also responsible for licensure. In some States it shares this function with other government agencies, and in a few States, the Hill-Burton agency has no licensing function. Other agencies of State government which frequently have some licensing responsibilities include Mental Health or Hygiene Departments and Welfare Departments.

Other Government Agencies

Local planning commissions, zoning boards, and the like should be consulted for information on

possible community development. State and local health departments should be requested to supply pertinent information on the prevalence of illness.

Publications

Guide issue of "Hospitals".—The guide issue of "Hospitals" magazine, published annually in August, contains data on individual facilities with respect to capacity, services, average occupancy, operating expenses, and other items.

Because of differences in reporting periods and other technical considerations, data presented in the guide issue may not be identical with corresponding data in State Hill-Burton Plans and other official sources. Furthermore, not all hospitals are listed in the guide issue.

Medical societies and directories.—Data on the hospital staff appointments and qualifications of physicians can be compiled from the Directory of Medical Specialists (7), the American Medical Directory (8), directories of local medical and osteopathic associations, and hospital medical staff lists. Information on every physician in the country is maintained on punch cards by the American Medical Association. This material covers both member and nonmember physicians. The American Osteopathic Association maintains similar data on every osteopath.

Population Data

Population data can generally be obtained from a variety of sources. The best-known of these is the U.S. Bureau of the Census. The Bureau conducts the regular decennial census and also makes numerous special censuses during the intervening years.

State and local health departments are frequently excellent sources of detailed population estimates and projections for municipalities and metropolitan areas. In developing such information, health departments use their extensive reservoir of birth and death statistics. Other sources which should be consulted for population data include regional planning commissions; school boards; chambers of commerce; power, telephone, and gas utilities; and water and sewer commissions. Church groups are also possible sources of population data, since they occasionally sponsor private censuses of local population.

If appropriate population figures are not readily available from the above sources, planning agencies can develop their own estimates and projections.

Other Sources of Health Facility Information

Other information may be obtained from prepayment plans, hospital and nursing home associations, and the Joint Commission on Accreditation of Hospitals (9). In areas with a high proportion of Blue Cross coverage, examination of claims data may provide some indication of patterns of hospital usage. Trends in prepayment coverage and costs of care may also be indicative of possible changes in future demand for institutional and out-of-hospital health services.

The types of data available from hospital and nursing home associations will vary widely. Planning agencies should consult with these organizations to determine the nature, extent, and usefulness of the information that they can provide. In addition, the accreditation status of each facility should be determined by contacting the Joint Commission.

CONDUCTING AN INITIAL AREAWIDE SURVEY

When existing data have been assembled, an initial areawide survey should be conducted to provide current, uniform, and detailed data about facilities.

Experience indicates that local planning agencies will greatly benefit from a comprehensive survey of health facilities in the planning region and that, at some point in the planning process, such a survey will become necessary.

Technical Benefits

A survey facilitates the collection of complete and uniform data. It enables planners to fill in gaps in existing knowledge and provides information sufficiently detailed for use in planning. In addition, the uniformity of survey data permits planners to make comparisons between individual facilities.

Organizational and Administrative Benefits

Facts developed in a comprehensive survey help to gain support for a planning effort and provide a basis for guiding and influencing facilities' construction plans. The definitive knowledge of capacities, capabilities, and potentialities of health facilities provided through a survey gives individual institutions an incentive to actively seek a planning agency's advice. This is one way in which planning agencies can develop opportunities to provide effective leadership.

At the inception of the planning process, some facilities may have misgivings about developing future construction plans in conjunction with planners, who are not accountable for facility operation. Properly handled, a survey can help to develop more constructive attitudes by building mutual trust between planning agency staffs and the sponsors and managers of facilities. A survey enables planners and participating facilities to work together and assists planning agencies to gain greater insight into the problems of individual institutions. In this way, a survey helps to develop rapport between facilities and planners and creates an atmosphere in which they can develop a constructive partnership in working toward common goals.

Planning groups should set definite and limited objectives for the initial health facility survey.

Experience indicates that the initial survey should be limited to a detailed inventory of existing facilities, services, and programs and a description of patterns of usage by both patients and physicians. Generally speaking, it should avoid questions about manpower, staffing costs, quality of care, reimbursement formulas, or any matter relating to the internal management and operation of facilities. If needed, data of this nature can be acquired later through special studies.

On the other hand, much of the information assembled through an initial survey will not be useful until the planning staff reaches the stage of working with individual facilities on their specific development programs. For this reason, within the limits of time and staff capabilities, it is usually best to assemble as much relevant information as possible initially, at one time and from all facilities, to anticipate later needs.

An initial health facility survey should obtain data useful in building support for the planning

effort; in providing an inventory of existing facilities, services, and programs; and in describing and evaluating the significance of patterns of usage by physicians and patients.

Several types of information can be obtained which are useful in helping to develop support for comprehensive health facility planning in the region. These include data on individual and aggregate construction plans of all institutions; the magnitude of total proposed expenditures for construction; the nature of existing coordinated relationships among facilities; and the extent of uneven, uneconomical, or inappropriate use of facilities. When measured against community needs and resources, these data can be used to demonstrate how economies can be effected through better planning.

Developing an Inventory of Facilities and Services

Data compiled from an initial survey should show the number, type, and distribution of beds, services, and programs. Such an inventory can be used to determine the availability of services in the community, to locate possible unnecessary duplication, and to discover gaps and deficiencies in service. Inventory data also provide a base point from which progress can be measured as planning proceeds.

Patterns of Hospital Usage

The initial survey should assemble data on patients' residence and on physicians' patterns of patient referral to hospitals. This can be done by collecting information showing the three-way link between physicians, patients, and hospitals on the same survey source document. These data will help hospitals to see the need for working with other hospitals and for developing administrative devices which will minimize the demand for additional facilities. They also will help planning agencies to offer guidance to hospitals developing construction programs.

Patient origin data show which hospitals are important to the residents of particular segments of the planning region and which geographic areas are important contributors to the patient load of each hospital. This kind of information frequently is useful for showing hospitals that future development can best be planned in relation to a particular population. In many cases,

patient origin data will also show hospitals that they share with nearby hospitals the role of providing care for the residents of particular areas.

Information on physicians' patterns of hospital admission is particularly important and would not be available in the absence of a survey. Almost all expansion in hospital beds reflects the desires of physicians for bed facilities to accommodate their patients. Information on patient referrals to hospitals by each physician will show each hospital what proportion of its medical staff admits patients to other hospitals and what proportion of its staff's patients are admitted to other hospitals. Data of this nature should never be made public or reported to hospitals in a manner which identifies individual physicians.

Hospitals, after analyzing such data, will realize that they share with other hospitals the task of meeting the total bed demands of staff physicians. Such data can also be used to show what proportion of a facility's medical staff refers patients wholly or primarily to it, and what proportion uses the facility principally for overflow when other hospitals are full. Knowledge of physicians' patterns of patient admissions to hospitals will also help to show facilities contemplating construction how, over the short-run, bed expansion may affect their occupancy and the occupancy of other facilities through transfer of patient referrals by physicians holding multiple staff appointments.

Survey questionnaires should be reviewed in advance by processing and tabulating specialists.

Review of questionnaires by data processing specialists is essential to assure ease in reviewing and handling completed survey forms and to ensure that proposed tabulations can be readily made with the type of data processing equipment to be used.

Examples of suggested survey questionnaires and tabulations, together with a discussion of many generally applicable principles relating to forms-design and survey techniques, are included in appendixes I and II. This material, however, should be regarded as illustrative only and should not be used without critical review of its applicability to particular local circumstances.

Survey data should be obtained from all facilities regardless of ownership.

In regions sufficiently large to justify the creation of a planning agency, it will generally be found that facilities are so diverse with respect to size, location, ownership, and population served that no one of them (or small sample) can properly be regarded as representative of the whole. In addition, to be of value, patient origin data must be obtained from substantially all facilities.

An initial survey should, therefore, cover all types of facilities—governmental and nongovernmental; long-term and short-term; general and special; inpatient and outpatient.

Medical societies, medical record librarians, administrators, and representatives of other interested or affected groups should be involved early in the process of developing a survey's format, organization, and timetable.

An initial areawide health facility survey will involve considerable work and expense on the part of hospitals and related facilities. At the outset, steps should be taken to insure their understanding and approval of survey objectives. Careful attention to these matters will help to secure the widest possible participation.

Liaison with interested groups can be established either through special committees established for the purpose of working with the planning agency in developing and conducting the survey, or through appropriate standing committees of institutional and professional organizations. These groups should be involved early in the process of developing a survey's format, organization, and timetable, and at later stages, they should be consulted on data analysis.

Review Committees

Proposed survey questionnaires should be reviewed by committees representing hospital administrators, physicians, and medical record librarians. Forms to be used in surveying long-term care facilities should be reviewed by nursing home administrators.

The purposes of establishing such review committees are (1) to insure that questions are clear and appropriate; (2) to insure that desired information is readily available; and (3) to ascertain whether proposed questions are fully acceptable to all professional groups.

Review of proposed questionnaires by medical record librarians is particularly important since they are the group most familiar with record-keeping procedures and the availability of data. Record librarians will also be called upon to do most of the actual work of completing survey questionnaires.

Acceptance and understanding of survey and planning goals by the medical profession will materially enhance the effectiveness of an areawide planning effort. Involvement of physicians in the planning process by requesting their advice and consultation in the development of survey forms and, to the extent possible, requesting their assistance in the analysis of data, can demonstrate how medical practice and professional judgment affect the quantity, quality, distribution, and cost of health facilities.

Proposed survey questionnaires should be field-tested prior to final adoption.

Survey forms should be pretested once they have been developed and approved in preliminary form. A few representative facilities should be asked to complete a small number of the tentative questionnaires and to report any difficulties to the planning agency. Observed deficiencies should be corrected before questionnaires are finally adopted.

Hospital administrators and medical record departments should receive adequate advance notice of a proposed survey.

All administrators should be informed of the purposes of the initial survey, its content, and other pertinent matters such as the confidential treatment of information regarding individual facilities and individual patients. This may be done through form letters, meetings, and in smaller planning regions by telephone. Information disseminated through these devices should also cover

the background and sponsorship of the survey and planning effort. If administrators are confident of the impartial and broadly representative nature of the planning group, they will more readily agree to participate in the survey.

In planning regions which include large numbers of institutions, a reply card for the administrator's signature should be enclosed with mailed notices to verify receipt.

Consideration should be given to sending a letter to each administrator for transmittal to the head of his medical record department. Such a letter would describe survey questionnaires in detail, discuss other technical information, and indicate deadlines for submission of data. Experience indicates that notification of medical record departments in advance of a survey helps them to prepare for the additional workload and stimulates accurate reporting. The possibility of holding an informational meeting with medical record librarians prior to a survey should also be considered.

Survey data, together with an interpretation, should be supplied to facilities as soon as possible after tabulation and analysis.

Facilities will not cooperate indefinitely with a planning agency's data collection program unless they see some tangible results. Tabulations should therefore be reported to facilities as quickly as possible after the completion of a regional survey. Reports should be accompanied by a short and simple interpretation of each table. If possible, a few sentences calling attention to significant points should accompany each table. Any tabulation requiring greater explanation is too complicated and should be simplified.

All tabulations should be dated and should show the source of the information. This is usually done with a footnote on each table.

PERIODIC REPORTING

After an initial survey has been completed and the data analyzed, continuing data collection mechanisms should be established.

Regularized data collection procedures will enable a planning agency to keep survey and other data up to date on a continuous basis. Properly

conceived, such regular reporting will keep planners in touch with events as they occur and minimize the reporting costs to hospitals.

Continuous reporting procedures should also be established to enable planning agencies to assemble needed data which are unavailable from

past hospital records and which cannot be developed adequately through a brief initial survey.

In addition, periodic reporting of data on a regular basis can help planning agencies to emphasize that planning is a continuing process, which consists, in part, of remaining alert to significant trends in order to initiate appropriate action.

Types of Regularly Reported Data

Daily occupancy reports.—Arrangements should be made for the regular collection of data needed to calculate daily occupancy by clinical service both for individual facilities and all facilities combined. Detailed daily records of patient census and bed complement for past periods are frequently unobtainable from hospitals. Consequently these data must be built up from current experience.

To obtain daily, uniform, and detailed occupancy information, planning agencies will first have to work with hospitals to gain agreement on the number of beds to be counted as part of each clinical service. Hospitals should then be requested to submit copies of their midnight census reports to the planning agency. These should be submitted on a weekly or monthly basis. Hospitals should also be asked to report major changes in bed complement as they occur.

Occupancy data of this nature can be arranged to show the number of beds occupied all of the time, some of the time and, perhaps, the number never occupied. In addition to showing the range of occupancy variation over a period of time, these data will show the frequency with which peaks and lows occur and whether occupancy generally reaches high or low points simultaneously in all hospitals.

Daily occupancy information can frequently be used to demonstrate that higher average occupancy rates are possible for short-term, acute facilities. It can also help to call a hospital's attention to situations in which more economical utilization can be achieved through administrative action, such as closure or conversion to other uses of low occupancy nursing units; reduction in

the number of beds in small, segregated, clinical departments; development among nearby hospitals of coordinated relationships designed to lessen fluctuations in occupancy; and better management of waiting lists (10, 11, 12).

These data are also useful in mapping differences in occupancy pressures in major clinical services in various parts of a planning region. This will help to identify metropolitan area needs for additional general hospital beds by type of service (13). These data are also needed to aid in gaining agreement on desirable occupancy rates as planning goals.

Medical staff appointments and physicians' qualifications.—Planning agencies should maintain a record of every hospital's medical staff showing the name, qualifications, privileges, and type of practice of each staff physician. Arrangements should be made for annual reporting by each hospital of new medical staff appointments and changes in physicians' privileges.

Individual hospitals rarely, if ever, have a complete picture of their staff members' other affiliations. As previously noted, pressures for new hospital construction are usually built up as a result of physicians' need for readily available facilities for their patients. Information on the proportion of physicians on each hospital's staff who hold single or multiple affiliations is consequently an important indicator of possible drives for new construction.

Medical staff lists can also help planning agencies to advise sponsors who are planning construction projects. Data on the facility's medical staff, or the kind of staff it would like to have, can be used in determining needed capacity as well as the nature of services to be provided. There is considerable reason to believe that in a given hospital the average length of stay and the range of services patients use will depend, in part, on the training and qualifications of staff physicians. Therefore, such information as the ratio of specialists to nonspecialists, surgeons to other physicians, and board-qualified and certified men to total medical staff assumes considerable importance in planning. Some of these data also provide an index of quality of care.

Chapter IV

Estimating Needs

FACTORS AFFECTING NEED ESTIMATES

An estimate of bed needs is important as a guide to planning officials and to individual facilities, but need calculation should not be the central goal of the entire planning effort. The number of beds needed will depend, in part, on programs of a social nature which provide alternatives to institutionalization. Since the effects of such programs must receive consideration, patient services of various kinds should be planned first and bed needs established later. Once decisions have been reached on the types of services to be provided in the planning region, these can be taken into account in the calculation of inpatient bed needs.

The Need Equation

The following method of calculating inpatient bed need is suggested:

| |
|--|
| $\frac{\text{Projected annual patient days in the target year}}{365 \times \text{average annual occupancy goal}} = \text{Number of beds needed}$ |
|--|

The number of patient days divided by 365 equals the average daily census, which is the average number of patients on a given day. Dividing average census by the expected average occupancy for the target year takes into account the additional beds needed to accommodate fluctuations in occupancy from day to day.

In the case of general hospitals, it is recommended that needs for medical-surgical, obstetrical and pediatric beds be calculated separately and then added to obtain total bed need.

Considerable judgment will be required in selecting the numbers to be entered in the need equation. Some of the considerations are discussed below.

Occupancy goals for health facilities within a planning region must be established before bed needs are calculated.

One factor that will materially affect the calculation of bed needs is the average occupancy rate at which facilities may be expected to operate. Planning agencies should establish a goal for average annual occupancy for each type of facility and for medical-surgical, obstetrical, and pediatric departments in general hospitals. These occupancy goals, rather than existing occupancy rates, should be used in the determination of bed needs.

Occupancy goals should be set at the highest rate considered desirable and consistent with economical operation for the particular type of facility or unit in question. While statistical data may be helpful, occupancy goals will most likely be set on the basis of expert opinion.

While the national average occupancy rate for non-Federal, general hospitals is about 75 percent, this rate should not necessarily be accepted as normal or desirable. Occupancy goals for medical-surgical departments should perhaps be set at 85 to 90 percent or more because of the control which can be exercised over elective admissions and the variety of conditions that may be treated in these types of beds.

Lower average occupancy for obstetrical and pediatric units and for small psychiatric departments will have to be accepted because of the relatively small size of the units, the uncontrollable variations in demand which occur throughout the year, and the restrictions on the types of patients who are permitted to occupy beds in these specialized departments.

As a general rule, smaller hospitals show a lower average occupancy than larger facilities. Communities with many small hospitals should, therefore, be prepared to accept a lower overall community rate of occupancy for a considerable period of time. They should, however, establish future occupancy goals that provide for consolidation of smaller hospitals into larger, more fully utilized facilities.

Calculating Patient Days

Perhaps the most obvious factor affecting bed need is the number of patient days of service that will arise. Patient days may be calculated in a number of ways as indicated below.

Patient-days = Admission rate \times population \times average stay, or

= Annual admissions \times average stay, or

= Use rate \times population

Admission rate = Annual admissions/unit of population

Average stay = Patient days/admission

Admissions = Admission rate \times population

Use rate = Annual patient days/unit of population

From the above, it can be seen that admission rate, average stay, and population are the chief determinants of the number of patient days of service required. It is well known that population size is determined by births, deaths, and net migration, all of which are taken into account in any reliable population projection. But what

factors influence length of stay and admissions? A long list could probably be compiled. The supply of physicians, the supply of beds, the extent of prepayment coverage, the economic and educational level of the population, and the current state of medical knowledge and medical practice are only a few of the factors that have been suggested.

Planning agencies will find that they have to make certain assumptions about future trends in length of stay and admission rates and take these into account, along with population projections, in estimating the number of patient days for the target year. In fact, some planning policies may actually promote changes in these factors. For example, preventive programs help to keep people from requiring hospitalization while home care programs and the presence of adequate long-term facilities help to reduce hospital use.

Developing a Series of Need Projections

Planning agencies should consider developing a series of need projections, each based on different assumptions about population, admissions, and length of stay in the target year. Such projections can be useful since the determination of future need is still an imprecise art which, in the last analysis, rests largely on experience and judgment. This does not mean that reasonable estimates of need cannot be calculated and that mathematical calculations should be discarded. Instead, it means that informed judgment should be exercised in making the assumptions reflected in the figures substituted in the need equation, and further, that need expressed as a range of possibilities is probably more realistic and more useful than a single need figure.

ILLUSTRATIVE NEED CALCULATION

Calculating general hospital bed needs is a basic tool in matching areawide resources to needs.

The following sections of this chapter contain an illustrative calculation of bed need for a hypothetical planning region with a target-year population of about 250,000. The example makes use of assumed figures which in actual practice would be obtained from health departments, hospitals, and related medical facilities. While an attempt has been made to use realistic figures in the illus-

tration, one should not assume that the need figures derived in the example will apply to any actual planning region with a quarter-million population.

The example illustrates one method of calculating need. For didactic purposes it carries out the calculations in considerable detail. In working out bed needs for an actual planning region, more or less detail can be used depending on the availability and quality of statistics pertaining to the particular area.

Step I—Calculating Total Projected Patient Days

The initial step in projecting the number of short-term, general hospital beds needed in the target year is a calculation of the expected total annual number of patient days. This is equal to the sum of projected patient days for each of the population's age and sex groupings. The number of projected patient days for each age and sex group may be derived by substituting the appropriate data in the following equation.

| | | | | |
|---|---|--|---|---|
| Projected population in thousands for the target year | × | Current patient days per thousand population | = | Projected patient days in the target year |
|---|---|--|---|---|

The figures on population and use rate are given in the example. In actual practice, these statistics would have to be obtained from local sources.

Calculating Total Projected Patient Days

| Age group | Projected population in thousands for target year | Present patient days per thousand population | Projected patient days in target year | Totals |
|--|---|--|---------------------------------------|---------|
| Males: | | | | |
| A. Under 15..... | 41.9 | 315.1 | 13,203 | |
| B. 15-24..... | 16.2 | 745.8 | 12,082 | |
| C. 25-44..... | 32.7 | 698.7 | 22,847 | |
| D. 45-64..... | 23.8 | 1,366.7 | 32,527 | |
| E. 65-74..... | 5.6 | 1,920.4 | 10,754 | |
| F. 75+..... | 2.5 | 1,945.1 | 4,863 | |
| G. Total projected patient days for males..... | | | | 96,276 |
| Females: | | | | |
| H. Under 15..... | 40.9 | 274.2 | 11,215 | |
| I. 15-24..... | 18.7 | 1,029.6 | 19,254 | |
| J. 25-44..... | 36.5 | 1,125.4 | 41,077 | |
| K. 45-64..... | 24.7 | 1,022.2 | 25,248 | |
| L. 65-74..... | 6.3 | 1,504.9 | 9,481 | |
| M. 75+..... | 3.2 | 1,924.1 | 6,157 | |
| N. Total projected patient days for females..... | | | | 112,432 |
| O. Total projected patient days (line G+line N)..... | | | | 208,708 |

Step II—Calculating Projected Patient Days for Major Clinical Services

The number of projected patient days for medical and surgical, pediatric, and obstetrical patients can now be calculated. Projected obstetrical and pediatric days are calculated individually from known data and subtracted from total projected patient days (line "O", Step I) to obtain the projected number of patient days from medical and surgical cases.

1. Calculating Projected Obstetrical Patient Days

| | | | | |
|------------------------------------|---|-------------------------------------|---|--------------------------------|
| Projected obstetrical patient days | = | Average length of stay per delivery | × | Projected number of deliveries |
|------------------------------------|---|-------------------------------------|---|--------------------------------|

- A. Projected number of females 15-44, in thousands (Step I, line I+line J.)..... = 55.2
- B. Current deliveries per 1,000 females 15-44 (Obtained from Health Departments or calculated from other available data.)... = 95.6
- C. Projected annual number of deliveries (Step II, line A × line B.)..... = 5,277.0
- D. Current number of hospital days per delivery (Data obtained either from Health Departments, or directly from hospitals. Use figures pertaining to local facilities only.)..... = 4.5
- E. Projected obstetrical patient days (Step II, line C × line D.)..... = 23,747.0

2. Calculating Projected Pediatric Patient Days

| | | | | | |
|----------------------------------|---|--|---|--|--|
| Projected pediatric patient days | = | Projected patient days for males under 15 (Step I, line A) | + | Projected patient days for females under 15 (Step I, line H) | |
|----------------------------------|---|--|---|--|--|

F. Projected pediatric patient days = 13,203 + 11,215 = 24,418

3. Calculating Projected Medical and Surgical Patient Days

| | | | | | |
|---|---|---|---|---|--|
| Projected medical and surgical patient days | = | Total projected patient days (Step I, line O) | - | Sum of projected obstetrical and pediatric patient days (Step II, line E plus line F) | |
|---|---|---|---|---|--|

G. Projected medical and surgical patient days = 208,708 - 48,165 = 160,543

Step III—Calculating Projected Average Daily Census

The following equation can be used to calculate projected average daily census:

| | | | | | |
|--------------------------------|---|------------------------|---|------------------------|--|
| Projected average daily census | = | Projected patient days | ÷ | Number of days in year | |
|--------------------------------|---|------------------------|---|------------------------|--|

| | Projected patient days (see step II) | Days in year | Average daily census |
|--|--------------------------------------|--------------|----------------------|
| A. Projected medical and surgical average daily census | 160,543 | ÷ 365 | = 439.8 |
| B. Projected pediatric average daily census | 24,418 | ÷ 365 | = 66.9 |
| C. Projected obstetrical average daily census | 23,747 | ÷ 365 | = 65.1 |

Step IV—Calculating Projected Bed Need

Assume that the planning agency has recommended the following occupancy goal:

| | Percent occupancy |
|---------------------------|-------------------|
| Medical and surgical beds | 85 |
| Pediatric beds | 75 |
| Obstetrical beds | 75 |

The equation below will then yield the number of beds needed.

| | | | | | |
|--------------------|---|----------------------|---|----------------|--|
| Projected bed need | = | Average daily census | ÷ | Occupancy goal | |
|--------------------|---|----------------------|---|----------------|--|

| | Projected average daily census (see step III) | Occupancy goal | Number of beds needed |
|---|---|----------------|-----------------------|
| A. Medical and surgical | 439.8 | ÷ .85 | = 517 |
| B. Pediatric | 66.9 | ÷ .75 | = 89 |
| C. Obstetrical | 65.1 | ÷ .75 | = 87 |
| D. Total short-term, general beds needed in the planning region | | | = 693 |

DETERMINING THE NEED FOR LONG-TERM FACILITIES

The need for long-term beds should be calculated on the basis of the size of the population that will be 65 years of age or older in the target year and on an occupancy goal of 95 percent or higher.

The same basic equation used for calculating short-term, acute bed need may be employed to determine the number of long-term beds required. The occupancy goal chosen for long-term beds, however, should be 95 percent or higher, and the number of patient days projected for the target year should be determined on the basis of the population 65 years of age and older.

Because of the prolonged length of stay associated with chronic illness, long-term facilities,

unlike general hospitals, are not characterized by wide day-to-day fluctuations in occupancy. As a result, average occupancy in nursing homes and other long-term facilities is usually rather high. In addition, the need for long-term facilities is particularly related to the older segments of the population, since the vast preponderance of chronic illness occurs in the older age groups.

Wide variations occur from State to State and within States with respect to the proportion of the total population represented by the aged. Therefore, figures used in calculating the projected number of long-term patient days should be based solely on population data relating to the aged population in the particular planning region.

Step V—Calculating Basic Long-Term Bed Needs

The ratio of persons receiving care in existing long-term facilities to the population 65 years of age and older should be determined as an initial step in calculating long-term bed needs. The magnitude of the present institutional population can usually be found in health department and/or welfare department statistics.

To continue the example, assume that appropriate data have shown that the present patient population of long-term care facilities represents 5 percent of the 65-and-over age group. While the calculation shown below is based on the continuation of present patterns of service, planning

officials should recognize that possible changes in the financing of care may bring about substantial changes in the demand for long-term beds.

1. Determining the Long-Term Average Daily Census

| | <i>Projected population 65 and over (see step I)</i> | <i>Long-term patients + population 65 and over</i> | <i>Average daily census</i> |
|---|--|--|-------------------------------------|
| A. Long-term average daily census | = 17,600 | × | 0.05 = 880 |

2. Determining the Number of Long-Term Beds Needed

| | <i>Long-term average daily census</i> | <i>Desirable occupancy rate</i> | <i>Long-term beds needed</i> |
|-----------------------------|---|---|--------------------------------------|
| B. Long-term beds needed .. | = 880 | ÷ | 0.95 = 926 |

REDUCING SHORT-TERM FACILITY NEED

Planning agencies should promote treatment programs and patterns of care which will minimize the need for additional short-term facilities.

A growing body of opinion maintains that some long-stay patients now customarily receiving care in general hospitals can be cared for adequately and at less cost per diem in long-term facilities. Planning agencies should, therefore, investigate possibilities for reducing short-term bed need by providing more nursing homes, chronic disease hospitals, and convalescent units. They may also wish to promote the development of home care, homemaker services, and other programs which may help to prevent or minimize the need for institutionalization.

Guidelines for coordinated planning of long-term care facilities have been provided in the report of a Joint Committee of the American Hospital Association and the Public Health Service, "Areawide Planning of Facilities for Long-Term Treatment and Care" (14).

One method of adjusting need calculations to reflect better balance between long- and short-term facilities is illustrated in the succeeding sections of this chapter.

A medical evaluation of long-stay patients in general hospitals is needed to determine the

extent to which additional long-term facilities can help to reduce short-term bed need.

Before basic long- and short-term bed needs can be further refined, a medical evaluation of a sample of long-stay patients in general hospitals should be conducted. Such an evaluation of in-patient population should be designed to determine the annual number of patient days by which the current load in general hospitals could be reduced if more long-term care facilities were to be made available. A parallel study should also be made to determine how many nursing home patients actually require care of the level usually provided only in a general hospital.

Planning agencies should work closely with medical societies, leaders of the medical profession and hospitals' utilization committees to develop detailed procedures for conducting such medical evaluations. As a general rule, these investigations should seek answers to the following questions with respect to long-stay general hospital patients:

1. How many long-stay patients require only convalescent or palliative care, and for how long?

2. How many long-stay patients appear to require permanent institutionalization?

3. On the average, what portion of the general hospital stay of patients who might be treated in alternative facilities is attributable to actual need for acute treatment?

ADJUSTING FOR LONG-TERM NEEDS

If a medical evaluation of long-stay general hospital patients shows that a reduction in average length of stay is possible, the basic long- and short-term bed needs calculated for the target year should be revised to promote a better balance between these types of facilities.

Whenever a medical evaluation of inpatient population shows that a significant proportion of the patient days in general hospitals is caused by long-stay patients requiring extended care of a less intensive nature, basic need calculations should be revised to provide for more long-term and fewer short-term beds.

Step VI—Recalculating the Number of Short-Term Beds Needed

Assume for the sake of illustration that such an evaluation of long-stay patients has been conducted and shows that 10 percent of the medical-surgical and pediatric patient days in the hypothetical planning region's general hospitals represents service to patients who could be cared for equally well in long-term facilities. Assume further that long-stay maternity cases are negligible. Given these facts, the possible reduction in general hospital bed needs can be calculated as follows:

1. Recalculating Projected Short-Term, Acute Patient Days

| | Projected patient days (from step II) | Percentage attributable to acute care | Revised projected short-term patient days |
|------------------------------|--|---------------------------------------|---|
| A. Medical and surgical..... | 160,543 | 0.90 | 144,489 |
| B. Pediatric..... | 24,418 | .90 | 21,976 |

2. Recalculating Projected Short-Term, Acute Average Daily Census

| | Revised projected short-term patient days | Days in year | Revised projected average daily census |
|-----------------------------|---|--------------|--|
| C. Medical and surgical.... | 144,489 | 365 | 396 |
| D. Pediatric..... | 21,976 | 365 | 60 |

3. Recalculating Projected Short-Term, Acute Bed Need

| | Revised projected average daily census | Desirable occupancy rate | Revised short-term bed need |
|---|--|--------------------------|-----------------------------|
| E. Medical and surgical.... | 396 | 0.85 | 466 |
| F. Pediatric..... | 60 | .75 | 80 |
| G. Obstetrical. (See step IV.)..... | | | 87 |
| H. Revised number of short-term, acute beds needed..... | | | 633 |

The need previously calculated for general hospitals was 693 beds. The revised need figure, 633 beds, indicates that 60 fewer beds will be needed if other types of facilities can absorb 10 percent of the patient days. The additional number of long-term beds needed to accommodate patients formerly treated in general hospitals can now be computed.

Step VII—Calculating Additional Long-Term Bed Need

Since the number of beds needed for short-term care has now been reduced, some of the patient days formerly programed for general hospitals will have to be accommodated in nursing homes or other long-term facilities. From Step VI, it is apparent that additional long-term beds will be needed for 18,496 patient days ($0.10 \times [24,418 \text{ pediatric days} + 160,543 \text{ medical and surgical days}]$). The number of additional long-term beds needed is calculated below.

1. Calculating the Additional Long-Term Average Daily Census

| | Additional long-term patient days | Days in years | Additional long-term average daily census |
|--|-----------------------------------|---------------|---|
| A. Additional long-term average daily census.. | 18,496 | 365 | 51 |

2. Calculating the Additional Number of Long-Term Beds Needed

| | Additional long-term average daily census | Desirable occupancy rate | Additional long-term beds needed |
|--|---|--------------------------------|---|
| B. Additional long-term beds needed..... | = 51 ÷ | 0.95 = | 54 |
| C. Basic long-term bed need. (Step V, Line B.)..... | | | 926 |
| D. Revised number of long-term beds that are needed..... | | | 980 |

Significant savings in construction costs are possible as a result of reducing the need for general hospitals by encouraging construction of adequate long-term facilities.

At first glance the net loss of six beds (i.e., 60 fewer short-term and 54 additional long-term) may not seem to yield sufficient savings to make the foregoing adjustment worthwhile. This, however, is not necessarily the case. The dollar saving in construction costs brought about by building 60 fewer general beds is calculated below, assuming that a modern facility of this type con-

tains approximately 700 square feet per bed and costs approximately \$29 per square foot.

60 beds \times 700 ft²/bed = 42,000 ft² of general hospital space eliminated.

\$29 per ft² \times 42,000 ft² = \$1,218,000 saving on general hospital beds.

The additional expense entailed in the construction of 54 additional nursing home beds may be similarly calculated, assuming in this case 500 square feet per bed and a cost of \$22 per square foot.

54 beds \times 500 ft²/bed = 27,000 ft² of additional space needed in long-term facilities.

\$22 per ft² \times 27,000 ft² = \$594,000 cost of additional long-term care beds.

| | | |
|--|---|-------------|
| Saving on general beds..... | = | \$1,218,000 |
| Cost of additional long-term beds..... | = | -594,000 |

| | | |
|----------------------------------|---|---------|
| Net saving to the community..... | = | 624,000 |
|----------------------------------|---|---------|

In the hypothetical planning region used in this illustration (population 256,000) the saving in construction costs amounts to \$2.44 for every man, woman, and child. Assuming a 25-year depreciation period, the community saves approximately \$25,000 annually in depreciation charges.

OTHER TYPES OF FACILITIES

Planning agencies should give adequate attention to determining needs for mental and other types of facilities.

The need for mental, tuberculosis, rehabilitation, and other specialized facilities cannot be determined with as great a degree of accuracy as can the need for general hospitals. Need for facilities devoted to single disease problems can change radically as the result of unforeseen circumstances, such as development of effective preventive measures, new methods of treatment, and changing patterns of care and financing.

Planning agencies may wish to employ projected patient days and desirable occupancy rates in determining the need for these types of facilities. On the other hand, the agency may choose only to promulgate minimum standards regarding facility size, location, comprehensiveness of treatment program, and other factors against which it can evaluate the merits of specific project proposals.

Psychiatric Facilities

The range of psychiatric services available at the community level needs to be increased in many parts of the country. This is especially true of services geared to the early diagnosis and intensive treatment of mental illness. While most inpatient psychiatric care is provided through State-operated mental hospital systems, local planning agencies can do much to promote more adequate psychiatric services. They can encourage the establishment of outpatient clinics, psychiatric nursing homes, short-term mental units in general hospitals, and facilities for aftercare such as half-way houses and foster homes.

Local planning agencies should work closely with State mental health and mental hospital officials to develop indices of need. This will entail gathering extensive information from public and private psychiatric facilities including, perhaps, those for the mentally retarded.

Patient data should include diagnosis, prognosis, and degree of security necessary. A special effort should be made to determine how many patients, especially older seniles, could be treated more appropriately in smaller decentralized units than in traditional, large, State mental institutions. An attempt should also be made to assemble data on the number of persons, normally residing in the planning region, who are currently receiving care in State and other mental hospitals.

In addition, an inventory of all local psychiatric facilities and services should be made. Information should be secured on mental patients receiving care in general hospitals and other local facilities. Particular effort should be made to establish the number of patients being treated in hospitals and clinics on an outpatient basis who would benefit from more intensive inpatient care.

Such special studies will assist local planning agencies to determine the need for and feasibility of additional community facilities for the diagnosis and treatment of mental illness, and the advisability of developing long-term psychiatric facilities to serve the planning region.

In developing programs for mental facilities, planning agencies should be guided by principles enunciated in the reports, "Planning of Facilities for Mental Health Services" (16) and "Action for

Mental Health" (16). In neither report was there a recommendation for construction of mental hospitals exceeding 1,000 beds. They also recommend wider geographic dispersion of mental health services especially those for early diagnosis and treatment. State governments and local planning agencies should work together to implement the recommendations contained in these two authoritative reports.

Tuberculosis and Rehabilitation Facilities

In planning for the development of comprehensive health services and facilities within the area, the planning agency will encounter special problems with regard to tuberculosis hospitals and rehabilitation facilities. These have been studied by two ad hoc committees whose reports will provide planning agencies with guidelines for the integration of these specialized services and facilities into the total complex of health facility planning. The rehabilitation report is available as "Area-wide Planning of Facilities for Rehabilitation Services," PHS Publication No. 930-B-2 (17). The report of the committee studying tuberculosis hospitals, "Areawide Planning of Facilities for Tuberculosis Services," (18) is expected to be published in the fall of 1963.

Chapter V

Later Planning Activities

SERVICE AREA DELINEATION

Consideration should be given to the need for creating a number of service areas within the planning region.

Many planning agencies, especially those covering a large geographic area, will find that their work will be facilitated by dividing the planning region into sub-areas or "service areas." Such areas should be considered as groups of people and territory for which coordinated facilities and services should be planned.

A number of planning groups have found that dividing a large region into smaller areas for planning purposes assists them in several ways. It helps them to think in terms of smaller units of population, smaller aggregations of facilities, and shorter distances and to insure that all segments of the region receive adequate attention. Service areas also help to call the attention of individual facilities to the importance of coordinating their programs with other institutions within the area.

Official Definition

A service area is defined as follows in the U.S. Public Health Service Regulations:

"The geographic territory from which patients come or are expected to come to existing or proposed hospital or medical facilities, the delineation of which is based on such factors as population distribution, natural geographic boundaries, and transportation and trade patterns, and all parts of which are reasonably accessible to existing or proposed hospital or medical facilities." (19)

Defining Service Area Boundaries

Patient origin data are particularly useful in defining service area boundaries. As a first step, this type of data should be shown on a map for each hospital. Patient origin for a particular facility may be represented either by dots on the map or by numbers entered in the appropriate census tracts, postal zones, or study areas, as the case may be.

The planning agency should send each hospital a copy of its patient origin map. The agency should then bring together those hospitals which appear to serve substantially the same territory. It should explain to them how multi-hospital service areas relate to the coordination of programming and work with them in defining area boundaries. Once a local planning group has agreed on service area boundaries, it should work with State Hill-Burton officials to secure adoption of these areas for use in the State Plan.

Criteria for Delineating Service Areas

Each service area should meet the following requirements:

1. It should conform to the definition of an area established for purposes of the Hill-Burton program.
2. It should contain a present or projected population sufficient to support a hospital of at least the minimum size adopted by the agency for its region. (While opinion varies, the

minimum size for a general hospital in metropolitan areas should probably be 150 to 200 beds.)

3. It should include territory for which population estimates and projections are regu-

larly available or for which such data can readily be prepared.

4. It should be delineated in such a manner that each major existing hospital will serve the area in which it is located.

ARCHITECTURAL EVALUATION

Architectural evaluation of existing facilities is an important step in the planning process. This should be undertaken objectively by the planning agency to provide a brief initial inventory of the physical plants. Later, individual hospitals will submit a complete feasibility survey and more detailed architectural and engineering data to support their final proposals before initiating construction.

The initial evaluation will assist the planning agency to assess the acceptability of existing facilities from the standpoint of their present and prospective future programs and to determine their potentialities for modernization and expansion.

Obsolescence is one of the most critical problems facing the nation's hospitals today. Architectural evaluation of these facilities is, therefore, important as a measure of the nature and extent of physical deficiencies. Among other things, such an evaluation helps to determine: (1) the suitability of existing plants on the basis of physical and functional factors; (2) whether a particular hospital's expressed future plans are realistic in relation to the existing plant; (3) the need for individual hospitals to revise their future construction and modernization programs if these appear to be unrealistic either because of excessive cost or technical problems; and (4) which existing hospitals should be replaced.

Architectural evaluation should not be undertaken too soon after the agency has been formed.

In no case should a planning group attempt to conduct an architectural study during its first year of operation. As a general rule, it is not desirable to initiate a program of physical plant evaluation until the agency has:

1. Collected all pertinent existing data and developed an up-to-date inventory of all types of facilities.

2. Developed estimates of need for beds and services irrespective of the condition of existing facilities.

3. Invited hospitals to submit proposals for their own future development.

4. Reviewed these proposals in relation to community needs and the aggregate construction and modernization plans of all facilities.

Architectural evaluations should be used to note deficiencies, but should not produce a theoretical modernization program for particular facilities.

Some planning groups have conducted architectural evaluations with architectural and engineering personnel employed directly by the agency. In other cases, agencies have employed an architectural firm on a contract basis.

The importance of the professional qualifications of evaluation team members cannot be over-emphasized. Many of the team's decisions and conclusions will be influenced by professional judgment. The evaluation team should be made up of architects and engineers with a broad background in hospital planning and design. Other persons with special competencies should be included in the evaluation team as needed. The hospital administrator, maintenance engineer, and other staff members who can contribute pertinent information should be asked to accompany the team and assist it during the evaluation.

The team should not attempt to draw up a theoretical modernization program for a facility, but rather should make a factual report on the

architectural and functional deficiencies in relation to its present bed and service program. Fire, health, and general safety hazards should be noted as well as deficiencies in functional arrangement, size of areas, and other physical characteristics affecting its future operation. The details of a modernization program for a particular

facility should be developed by the facility and its own architect and submitted to the planning agency for approval prior to commencing work.

Procedures for conducting architectural evaluations are presently being field-tested and will be described in a future Public Health Service publication.

EDUCATIONAL ACTIVITIES

Local planning agencies should acquaint health facilities with the wide range of financial resources available for health facility construction.

Local planning agencies should, wherever necessary, seek to encourage use of all the financial resources available for health facility construction. While a major share of the cost of health facility construction will probably be borne by the local community in most instances, local planning officials should apprise facilities and the public of the availability of assistance from various government programs.

Federal funds are available for construction of particular types of facilities through the Hill-Burton program and the Health Research Facilities Program administered by the Public Health Service. Limited aid is available under the Public Facility Loans Program, and the Advances for Public Works Planning Program and the College Housing Loan Program, administered by the Housing and Home Finance Agency. In addition, there are several Federal programs providing loans for proprietary facilities.

Many States have statutes which in one way or another help to provide financial aid for the construction, expansion and/or modernization of hospitals and related facilities. Included among these statutes are laws authorizing (1) the establishment of hospital districts; (2) laws providing for State grants; (3) laws authorizing leases of facilities constructed with public funds for operation by nonprofit groups; and (4) laws authorizing

counties and municipalities to construct public hospitals or in various ways to aid nonprofit facilities serving their residents.

Planning groups should acquaint facilities and the public with planning goals and community needs.

Education and persuasion are also important activities through which local planning groups can influence construction. Their broad and detailed knowledge of regional needs, existing facilities and resources, programs and patterns of usage should be particularly effective in helping project sponsors to develop desirable construction programs.

In addition, educational activities should be carried on by the planning agency as a means of encouraging needed construction. Among other things, a planning agency's educational program should:

1. Seek to stimulate philanthropic giving through the publication of planning goals emphasizing the long-run savings in construction cost which may result if they are achieved.
2. Encourage the owners of existing short-term facilities not eligible for modernization or replacement to consider sponsoring much-needed alternative types of health facilities.
3. Appeal to recognized charitable organizations to consider building and operating facilities other than general hospitals.
4. Encourage general hospitals to undertake broadened care and treatment programs.

IMPLEMENTATION

Implementation of a plan or program is a continuing process, beginning with the formation of the planning agency and accompanying all stages of operation.

One of the most difficult tasks which planning agencies will face is that of implementing recommendations for the future development of health facilities in the planning region. Successful action to carry out planning recommendations will depend upon the extent to which the planning agency has gained and kept public support and confidence and the cooperation of health facilities, State authorities, and others concerned with health programs.

The building of confidence in the planning agency and support for its program is inherent in many of the activities described in this document.

Consequently, implementation of planning decisions has not been discussed as a separate subject. Implementation begins with the first effort to secure the understanding and support of health facilities, physicians, health and welfare groups, and other organizations. At later stages, speeches, forums, and press coverage help to apprise the public of the planning effort and to develop community interest. Throughout the life of the planning agency, continuing education of the public and the health field helps to gain agreement on planning goals and to develop public awareness and support. Above all, however, success of a planning effort will depend largely on the ability of the planning agency to work with facilities and to assist them in developing workable programs which effectively meet both the needs of the individual facility and the needs of the community.

Appendix I

Suggested Survey Questionnaires

One of the initial problems facing a local planning agency is the development of data collection questionnaires for use in an initial areawide survey. This appendix contains four illustrative survey schedules; (1) Hospital Information; (2) Inpatient Information; (3) Outpatient Information; and (4) Long-Term Care Facility Information. These forms have been developed as examples only. While they have been field-tested, they should not be adopted for actual use without first being subjected to the local review and clearance procedures recommended in Chapter III of this manual.

The illustrative questionnaires incorporate a number of design features which should be noted by those planning to conduct an areawide survey. These special features and other matters relating to the design and use of the suggested forms are discussed below. The questionnaires appear on pages 38-53.

Special Features of the Questionnaires

Simplicity.—A number of simplifying devices have been incorporated in the survey schedules to make the submission of data easier for reporting facilities. First, all instructions appear directly on the questionnaires eliminating separate (and sometimes confusing) instruction sheets. In addition, the survey deadline, the return address, and the survey staff's telephone number appear at the beginning of each questionnaire. Blank lines in the masthead of the illustrative forms show where this information would be printed in actual practice.

It should also be noted that the schedules are designed for easy completion. Most questions require making only a single entry on a blank line

or checking an appropriate box. The "yes" and "no" format of the check-box type questions requires that one box be checked for each item. In this way, if a question is accidentally overlooked and left blank, it can be tabulated as "not reported" rather than "no." The instruction to "Complete all items" in blank-line type questions also helps to distinguish between omissions and negative responses.

Another simplifying device is the facility number. This is an individual identification number assigned to each facility by the planning agency. The survey staff should print or stamp a facility's identification number in the space provided before forms are mailed or delivered for completion. In this way, each participating facility is relieved of the task of entering its name on every survey document. By adding extra digits to the identification number, this device can also be used to indicate a facility's location, type of ownership, and accreditation status, and to code other data derived from published sources.

The form number.—The form number space is provided on the inpatient and outpatient questionnaires for the purpose of entering an individual identification number on each hospital's completed survey forms. If a given hospital were to return, say, 400 inpatient forms, these would be numbered consecutively from 1 to 400. Outpatient forms returned by the same facility would be numbered in the same way, also beginning with 1. Form numbers should be entered by the survey staff as soon as completed questionnaires are received.

This procedure furnishes a count of the survey documents completed and the number of patients covered. The form number also provides a convenient method of linking a particular questionnaire with its corresponding punch card. The

inclusion of the form number on both the punch card and its source document facilitates the replacement of lost or mutilated cards. It is also useful in insuring that a card is punched for each completed questionnaire.

The detachable strip.—Another important feature of the inpatient and outpatient questionnaires is the detachable strip at the very top of the page. It contains a space for entering the patient's name and chart number. In actual practice, the page would be perforated where the dotted line appears on the printed illustrative form.

Since different parts of the questionnaires may have to be completed by different offices within the hospital, it is important for hospital personnel to be able to identify each form with a particular patient. When all information has been entered, patient identification is no longer needed and the perforated strip can be detached before returning the completed questionnaire to the survey staff for tabulation. This procedure prevents disclosure of patient's identity.

Collecting Information on Physicians

Question J on the inpatient questionnaire is provided for the purpose of identifying the patient's physician. This can be done in a number of ways. Either the physician's name or his Blue Cross physician's code number can be entered in the space provided. The latter procedure is recommended since use of the code number will eliminate problems resulting from illegible handwriting and the confusion that may occur if two or more physicians should happen to have the same name.

A space is provided at the top of the inpatient information questionnaire for entering additional coded information about the physician. This data would be inserted by the survey staff and may include information on the physician's age, sex, specialty, number of hospital connections, place of residence and location of principal office. This type of data is usually readily available from published sources.

Methods of Collecting Data on Patient Origin and Physician Location

Telephone prefix areas, postal zones, census tracts, special study areas, and political boundaries have all been used by hospital surveys in the past as devices for recording patient residence.

Each of these methods has advantages and disadvantages which may make one or another preferable depending on the extent of the region to be surveyed, the total number of patients likely to be covered, the amount of time available, the size of the survey staff, and the amount of money available to the planning agency.

Census tracts.—In general, collecting patient origin data in a manner that can be tabulated by census tract will prove to be the most satisfactory way of gathering patient origin information. The illustrative questionnaires have been set up to accommodate this method. The employment of census tracts makes possible the tabulation of residence information according to small geographic units for which current population estimates and projections are available or can readily be developed.

The use of census tracts requires the reporting of a street address for each patient. This does not, however, jeopardize patient anonymity since an exact house number is not needed. The number of the block in which the patient's residence is located is sufficient to assign an address to a tract.

The appropriate census tract should be determined from reported data by the survey staff. They will have to use a census tract directory in assigning each address to its proper tract. The number of the census tract should then be entered in the space provided. This space is located in the right-hand portion of the masthead in both the inpatient and outpatient questionnaires.

At this point, perhaps, a review of other methods of gathering patient origin information is in order since each of these may be useful in some situations.

Telephone prefix areas.—Telephone exchange areas have several advantages. They cover the entire inhabited territory of any region. All physician's offices and most patients' homes have telephones. Hospitals invariably have records of physicians' and patients' telephone numbers. Anonymity of patients can be preserved since addresses need not be reported and the telephone exchange can be recorded quickly and easily.

Among the disadvantages associated with this method of obtaining residence data is the fact that some patients, especially indigents, do not have telephones. This can be overcome by requesting the phone number of a nearby neighbor or the patient's full address. Other difficulties may be encountered because of "foreign exchanges" which are prefix areas which overlap, but these, too, can

be overcome if necessary. A third drawback results from the fact that population figures for telephone exchange areas usually do not exist.

Postal zones.—Postal zones offer a quick and convenient device for gathering and tabulating data on residence. They, too, have the advantage of being easy to record and of preserving the anonymity of patients. In addition, there are no economic barriers to having a postal zone (as there are in having telephone service). Furthermore, maps of the street boundaries of postal zones can usually be found in the telephone directory.

The chief barrier to using postal zones is the fact that many suburban, interurban, and rural areas surrounding central cities are not zoned. This difficulty can be remedied by assigning an identifying code number to each outlying community.

As in the case of telephone prefix areas, population data by postal zone probably will not be available. Figures on the number of dwelling units in each zone, however, may be obtainable from the post office and, if so, a very rough estimate of the population of each zone can be made if recent local data on the average number of persons per dwelling unit are available. Popu-

lation estimates made in this manner, however, should not be regarded as reliable.

Special study areas.—Some planning agencies may wish to devise special study areas. In general, the use of special study areas in gathering patient origin data will have the same advantages and disadvantages as the employment of census tracts. In the case of special study areas, however, it will be more difficult to determine the current or projected population unless the study areas themselves are composed of combinations of census tracts or other geographic areas for which population data are readily available.

Political boundaries.—Planning regions containing large central cities will probably find that political boundaries are unsatisfactory for use in collecting patient origin data. In such cases, data treating the central city as a single unit will yield insufficient detail.

Political boundaries, however, may be satisfactory in rural areas and in regions containing small central cities. Their use as a data-collection device has the advantages of being readily available from hospital records, not requiring the recording of street addresses, and being readily correlated with population data.

THE HOSPITAL INVENTORY FORM

The hospital inventory questionnaire is designed to provide basic data regarding the characteristics and capabilities of existing hospitals within the planning region. Specifically, the information requested includes the services available at each facility, educational programs, coordinated relationships with other facilities and organizations, recent operating statistics, recent construction, plans for future construction, anticipated sources of financing and modernization needs.

This questionnaire should be completed by all short-term, acute general and special hospitals. Data submitted on this form, however, should not include information for long-term units in such facilities.

Several copies of the questionnaire should be sent to each facility to allow for spoilage and to permit hospitals to retain copies for their own files.

Hospital Information

| | |
|---|------------------------|
| Please return one copy of this form to _____ By _____ 19__ For further information call the following telephone number: _____ | <i>Facility number</i> |
|---|------------------------|

In questions A through F, indicate whether the types of services listed are available at this hospital for its patients.

Check "Yes" or "No" for each item.

A. Laboratory Services

- | Yes | No | |
|-----------------------------|-----------------------------|------------------------|
| <input type="checkbox"/> 1. | <input type="checkbox"/> 2. | Animal laboratory |
| <input type="checkbox"/> | <input type="checkbox"/> | Autopsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Bacteriology |
| <input type="checkbox"/> | <input type="checkbox"/> | Biochemistry |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood bank |
| <input type="checkbox"/> | <input type="checkbox"/> | Bone bank |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye bank |
| <input type="checkbox"/> | <input type="checkbox"/> | Hematology |
| <input type="checkbox"/> | <input type="checkbox"/> | Histology |
| <input type="checkbox"/> | <input type="checkbox"/> | Parasitology |
| <input type="checkbox"/> | <input type="checkbox"/> | Serology |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (specify below.) |
| | | _____ |
| | | _____ |

B. Radiological Services

- | Yes | No | |
|-----------------------------|-----------------------------|-------------------------|
| <input type="checkbox"/> 1. | <input type="checkbox"/> 2. | Diagnostic X-ray |
| <input type="checkbox"/> | <input type="checkbox"/> | Fluoroscopy |
| <input type="checkbox"/> | <input type="checkbox"/> | Therapy |
| <i>Radioisotope</i> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diagnostic tracer |
| <input type="checkbox"/> | <input type="checkbox"/> | External bomb |
| <input type="checkbox"/> | <input type="checkbox"/> | Radium |
| <input type="checkbox"/> | <input type="checkbox"/> | Therapy (general) |
| <input type="checkbox"/> | <input type="checkbox"/> | Therapy (interstitial) |
| <input type="checkbox"/> | <input type="checkbox"/> | Therapy (intracavitary) |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (specify below.) |
| | | _____ |
| | | _____ |

C. Obstetrical Services

- | Yes | No | |
|-----------------------------|-----------------------------|----------------------------|
| <input type="checkbox"/> 1. | <input type="checkbox"/> 2. | Delivery |
| <input type="checkbox"/> | <input type="checkbox"/> | Newborn nursery |
| <input type="checkbox"/> | <input type="checkbox"/> | Premature infant care unit |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (specify below.) |
| | | _____ |
| | | _____ |

D. Surgical Services

- | Yes | No | |
|-----------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> 1. | <input type="checkbox"/> 2. | Artificial kidney |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac monitoring |
| <input type="checkbox"/> | <input type="checkbox"/> | Cranial surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Cystoscopy |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | General surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurological surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Open heart surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Orthopedic surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Plastic surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Postoperative recovery room |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (specify below.) |
| | | _____ |
| | | _____ |

E. Social Services

- | Yes | No | |
|-----------------------------|-----------------------------|--|
| <input type="checkbox"/> 1. | <input type="checkbox"/> 2. | Patient and family counseling |
| <input type="checkbox"/> | <input type="checkbox"/> | Patient discharge planning and placement |
| <input type="checkbox"/> | <input type="checkbox"/> | Social history and evaluation |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (specify below.) |
| | | _____ |
| | | _____ |

F. Outpatient Services or Clinics

- | Yes | No | |
|-----------------------------|-----------------------------|--------------------------------------|
| <input type="checkbox"/> 1. | <input type="checkbox"/> 2. | Chest |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental |
| <input type="checkbox"/> | <input type="checkbox"/> | Dermatological |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetic |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye, ear, nose and throat |
| <input type="checkbox"/> | <input type="checkbox"/> | Epileptic |
| <input type="checkbox"/> | <input type="checkbox"/> | Evaluation and followup |
| <input type="checkbox"/> | <input type="checkbox"/> | Gynecological |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart |
| <input type="checkbox"/> | <input type="checkbox"/> | Medical diagnostic |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental |
| <input type="checkbox"/> | <input type="checkbox"/> | Orthopedic |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical medicine and rehabilitation |
| <input type="checkbox"/> | <input type="checkbox"/> | Podiatry |
| <input type="checkbox"/> | <input type="checkbox"/> | Prenatal |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatological |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgical |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumor |
| <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Well baby |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (specify below.) |
| | | _____ |
| | | _____ |

Hospital Information—Continued

G. Physical medicine and rehabilitation services

- | Yes | No | |
|-----------------------------|-----------------------------|------------------------|
| <input type="checkbox"/> 1. | <input type="checkbox"/> 2. | Occupational therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Recreational therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (specify below.) |

H. Other services

- | Yes | No | |
|-----------------------------|-----------------------------|------------------------|
| <input type="checkbox"/> 1. | <input type="checkbox"/> 2. | Convalescent unit |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental unit |
| <input type="checkbox"/> | <input type="checkbox"/> | EEG. |
| <input type="checkbox"/> | <input type="checkbox"/> | EKG. |
| <input type="checkbox"/> | <input type="checkbox"/> | Electromyography |
| <input type="checkbox"/> | <input type="checkbox"/> | Emergency room |
| <input type="checkbox"/> | <input type="checkbox"/> | Home care program |
| <input type="checkbox"/> | <input type="checkbox"/> | Intensive care unit |
| <input type="checkbox"/> | <input type="checkbox"/> | Intermediate care unit |
| <input type="checkbox"/> | <input type="checkbox"/> | Long-term care unit |
| <input type="checkbox"/> | <input type="checkbox"/> | Pharmacy |
| <input type="checkbox"/> | <input type="checkbox"/> | Self care unit |
| <input type="checkbox"/> | <input type="checkbox"/> | Disaster plan |
| <input type="checkbox"/> | <input type="checkbox"/> | Fallout shelter |
| <input type="checkbox"/> | <input type="checkbox"/> | Inhalation therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric unit |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (specify below.) |

I. Committees

Does the medical staff maintain the following regularly functioning committees?

- | Yes | No | |
|-----------------------------|-----------------------------|--|
| <input type="checkbox"/> 1. | <input type="checkbox"/> 2. | Admission, discharge or utilization committees |
| <input type="checkbox"/> | <input type="checkbox"/> | Credentials committee |
| <input type="checkbox"/> | <input type="checkbox"/> | Medical record committee |
| <input type="checkbox"/> | <input type="checkbox"/> | Tissue committee |

Do the trustees, either jointly with the medical staff or separately, maintain the following type of committee?

- | | | |
|-----------------------------|-----------------------------|--------------------|
| <input type="checkbox"/> 1. | <input type="checkbox"/> 2. | Planning committee |
|-----------------------------|-----------------------------|--------------------|

J. Twenty-four-hour staffing

Are the following types of personnel on duty in the hospital (not on call from home) 24 hours a day to staff the departments, or provide the services indicated below? (Check "yes" only where such persons are regularly assigned to such departments or duties, or are available in the hospital whenever needed.)

- | Yes | No | |
|-----------------------------|-----------------------------|-------------------------------------|
| <input type="checkbox"/> 1. | <input type="checkbox"/> 2. | Nurses (for the delivery room) |
| <input type="checkbox"/> | <input type="checkbox"/> | Nurses (for the emergency room) |
| <input type="checkbox"/> | <input type="checkbox"/> | Nurses (for surgery) |
| <input type="checkbox"/> | <input type="checkbox"/> | Physician to provide emergency care |
| <input type="checkbox"/> | <input type="checkbox"/> | Technician (X-ray) |
| <input type="checkbox"/> | <input type="checkbox"/> | Technologist (laboratory) |

K. Coordination with health departments

Indicate which of the following functions or activities are carried out through an agreement, or agreements, with a health department, or departments.

- | Written
Agreement | Informal
Or Oral
Agreement | No
Program | |
|-----------------------------|----------------------------------|-----------------------------|---|
| <input type="checkbox"/> 1. | <input type="checkbox"/> 2. | <input type="checkbox"/> 3. | Providing housing for health department laboratories or offices |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Operating a laboratory for a health department |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sharing personnel with a health department |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer registry: State Health Department |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other (specify)----- |

L. Coordination with nursing homes and other long-term facilities

Indicate which of the following functions or activities are carried out through an agreement, or agreements, with one or more nursing homes or chronic disease hospitals.

- | Written
Agreement | Informal
Or Oral
Agreement | No
Program | |
|-----------------------------|----------------------------------|-----------------------------|--|
| <input type="checkbox"/> 1. | <input type="checkbox"/> 2. | <input type="checkbox"/> 3. | Consultation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sharing of personnel |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Training of home's staff by hospital |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Performance of laboratory work for home by the hospital's lab. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Geriatric training for hospital's medical staff, nursing staff and/or professional students provided by or at the home |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hospital provides acute care for patients of home when necessary |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other (specify)----- |

Hospital Information—Continued

M. Coordination with other facilities

Indicate which of the following functions or activities are carried on through an agreement, or agreements, with any other hospital(s), health facility(s), private organization(s) or government agency(s).

| Written Agreement | Informal Or Oral Agreement | No Program | |
|--------------------------|----------------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Joint recruiting of personnel |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Joint purchasing |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Joint training programs for nonprofessional hospital personnel |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Sharing of dietary department |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Joint use of cobalt or cesium unit |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Joint use of other X-ray therapy equipment |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Joint laundry |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. Sharing of personnel |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Joint use of iron lung |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10. Joint use of EEG. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 11. Joint use of artificial kidney |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 12. Other (specify)..... |

N. Utilization of inpatient services

Enter data for the year ended 19..

If none, enter "X". Complete all items.

1. Number of admissions except newborn
2. Number of discharges including deaths
3. Total inpatient days excluding newborn
4. Total days of care rendered to discharged patients
5. Number of live births
6. Number of still births
7. Number of abortions
8. Total newborn days

6. Number of artificial kidney procedures
7. Number of diagnostic X-rays
8. Number of "major" operations
9. Number of "minor" operations
10. Number of EEG.
11. Number of EKG.
12. Number of patients receiving physical therapy

O. Utilization of selected services by inpatients and outpatients

Enter data for the year ended 19..

If no program, enter "X". Complete all items.

1. Number of cobalt or cesium treatments
2. Other deep therapy
3. Radium and radioisotope therapy procedures
4. Number of diagnostic radioisotope studies
5. Number of open heart operations

P. Utilization of outpatient department

Enter data for the year ended 19..

If no program, enter "X". Complete all items.

| Number of visits | Admissions | Type of outpatient |
|---------------------|------------|-----------------------|
| | | 1. Emergency |
| | | 2. Clinic |
| | | 3. Physician referred |

Q. Types of accommodations

If none, enter "X". Complete all items.

| Number of beds | Number of rooms | |
|-------------------|--------------------|------------------------------|
| | | 1. One-bed rooms |
| | | 2. Two-bed rooms |
| | | 3. Three- or four-bed rooms |
| | | 4. Rooms with over four beds |

Hospital Information—Continued

R. Undergraduate and paramedical student training

Enter the number of students in the most recently completed classes or programs. If no program, enter "X". Complete all items.

| | Affiliating students | Hospital-operated school | |
|-----------------------------------|----------------------|--------------------------|----------|
| | | Capacity | Students |
| 1. Dietetics | | | |
| 2. Librarianship | | | |
| 3. Undergraduate medical students | | | |
| 4. Medical records | | | |
| 5. Clinical laboratory technology | | | |
| 6. Registered nurse | | | |
| 7. Licensed practical nurse | | | |
| 8. Nurse, anesthetist | | | |
| 9. Occupational therapy | | | |
| 10. Pharmacy | | | |
| 11. Physical therapy | | | |
| 12. Social work | | | |
| 13. X-ray technology | | | |
| 14. Hospital administration | | | |
| 15. Undergraduate dental students | | | |
| 16. Other (specify.) | | | |
| | | | |

S. Medical internship program

If no program, enter "X". Complete both items.

1. _____ Number of approved medical internships.
2. _____ Number of interns in most recently completed class.

Hospital Information—Continued

T. Medical residencies

Enter the number of approved residencies and the number of residents in the most recently completed classes. If no program, enter "X". Complete all items.

| | Residencies | Residents |
|---|-------------|-----------|
| 1. Dermatology and syphilology | | |
| 2. Internal medicine | | |
| 3. Allergy | | |
| 4. Gastroenterology | | |
| 5. Pulmonary diseases | | |
| 6. Neurology | | |
| 7. Pediatrics | | |
| 8. Allergy (Pediatric) | | |
| 9. Physical medicine and rehabilitation | | |
| 10. Psychiatry | | |
| 11. Anesthesiology | | |
| 12. General surgery | | |
| 13. Neurological surgery | | |
| 14. Cardiovascular diseases | | |
| 15. Obstetrics and gynecology | | |
| 16. Ophthalmology | | |
| 17. Orthopedic surgery | | |
| 18. Otolaryngology | | |
| 19. Plastic surgery | | |
| 20. Proctology | | |
| 21. Thoracic surgery | | |
| 22. Pathology | | |
| 23. Urology | | |
| 24. Radiology | | |
| 25. Contagious diseases | | |
| 26. General practice | | |
| 27. Malignant diseases | | |
| 28. Occupational medicine | | |

Hospital Information—Continued

U. Bed complement

Enter the number of beds in each clinical service.

If none, enter "X". Complete all items.

Item #14 should equal the total of items #1 through 13.

| Clinical service | Beds in operation 5 years ago, 19.. | Beds currently in operation | Beds currently under construction | 5-year projected construction 19..-19.. | | |
|---------------------------|-------------------------------------|-----------------------------|-----------------------------------|--|---------------------------------|----------------------------------|
| | | | | Gross construction; i.e., total new beds | Beds to be lost in construction | Anticipated bed complement, 19.. |
| 1. Medical | | | | | | |
| 2. Surgical | | | | | | |
| 3. Obstetrical | | | | | | |
| 4. Convalescent | | | | | | |
| 5. Communicable diseases | | | | | | |
| 6. Chronic diseases | | | | | | |
| 7. Tuberculosis | | | | | | |
| 8. Genitourinary | | | | | | |
| 9. Gynecological | | | | | | |
| 10. Orthopedic | | | | | | |
| 11. Psychiatric | | | | | | |
| 12. Pediatric | | | | | | |
| 13. Other (specify.) | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| 14. Total beds | | | | | | |
| 15. Bassinets for newborn | | | | | | |

Hospital Information—Continued

V. Past and prospective sources of funds for construction

Enter the number of dollars expected from each source to finance contemplated construction, expansion, and/or modernization during the next 5 years, and the amount and sources of funds provided for such purposes during the last 5 years.

If none, enter "X". Complete all items.

| | Last 5 years 19...-19... | Next 5 years 19...-19... | <div style="border: 1px solid black; padding: 2px; display: inline-block;"> Check below if amounts entered are estimated </div> | |
|---|-----------------------------|-----------------------------|---|--------------------------|
| | | | Last 5 yrs. | Next 5 yrs. |
| 1. Total, all sources | | | | |
| 2. Hospital funds | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Corporate gifts | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Private gifts (itemize below.) | | | <input type="checkbox"/> | <input type="checkbox"/> |
| (a) Hospital employees | | | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Medical staff | | | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Hospital trustees | | | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Hospital auxiliary | | | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Major individual gifts | | | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Public subscriptions | | | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Other private gifts | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Foundations | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Federal grants | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. State and local government grants | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Grants or gifts from affiliated church group | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Loans from affiliated church group | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Commercial loans | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Bond issues | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Tax revenues | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Other sources | | | <input type="checkbox"/> | <input type="checkbox"/> |

Hospital Information—Continued

W. Modernization Needs

In the space provided below, indicate the extent of any modernization, expansion or replacement needed. If needed work is under way or definitely planned, please indicate this in the discussion.

1. Administration department
2. Central supply
3. Dietary department
4. Emergency department
5. Employees' facilities
6. Laboratory and pathology

Hospital Information—Continued

7. Laundry and housekeeping.....
.....
.....
.....
.....
.....
.....
8. Mechanical facilities.....
.....
.....
.....
.....
.....
.....
9. Nursing units.....
.....
.....
.....
.....
.....
.....
10. Occupational therapy.....
.....
.....
.....
.....
.....
.....
11. Pharmacy.....
.....
.....
.....
.....
.....
.....
12. Physical therapy.....
.....
.....
.....
.....
.....
.....
13. Stairs, corridors, etc.....
.....
.....
.....
.....
.....
.....

Hospital Information—Continued

14. Supply

15. Surgery _____

16. X-ray and radiology.....

17. Other _____

THE INPATIENT INFORMATION FORM

The inpatient information questionnaire will provide data on each patient and his physician, including each patient's place of residence, age, sex, length of stay, and type of accommodation. In addition, it will produce information on clinical service, discharge to other facilities, and method of payment.

One copy of this form should be completed for each patient, except newborn, discharged from short-term facilities during a selected survey period. Discharges should include deaths. The inpatient survey should cover a period of not less than 2 weeks and preferably a month or longer. A 2-week period will probably permit the gathering of information on 100 or more discharges from all but the smallest hospitals. In at least one city a patient origin study lasting 6 months has been conducted.

Information requested on the inpatient information questionnaire is restricted to discharged patients to assure that data will cover complete

periods of hospitalization. Thus, information can be collected on length of stay, method of payment, and discharge to other facilities, which would not be possible if the survey pertained to patients whose stay was not complete.

Newborn are not included in the inpatient survey since place of residence for newborn children would be the same as that of their mothers. Inclusion of newborn would consequently distort residence data. Annual statistics on newborn are requested on the hospital information questionnaire. Some planning agencies may wish to consider including newborn who remain in the hospital as pediatric cases subsequent to their mother's discharge.

In general, the number of survey forms sent to each facility should be equal to the bed count plus 20 percent multiplied by the number of weeks in the survey period. This will provide most facilities with the needed number of forms plus a few to spare.

Inpatient Information

Patient's name Case #

This portion of the questionnaire must be detached before returning to survey staff

| | |
|--|---|
| <p>Complete one copy of this form for each inpatient discharged between 19.. and 19.. (Include deaths.) Return this form to by 19.. For further information call this number</p> | <p style="text-align: center;"><i>This space for staff use only</i></p> <p>Census tract Facility # Physician Form #</p> |
|--|---|

| | |
|---|---|
| <p>A. Location of patient's home:</p> <p><input type="checkbox"/> 1. Out of State</p> <p><input type="checkbox"/> 2. Central city</p> <p><input type="checkbox"/> 3. Suburb A</p> <p><input type="checkbox"/> 4. Suburb B</p> <p><input type="checkbox"/> 5. Suburb C</p> <p><input type="checkbox"/> 6. Suburb D</p> <p><input type="checkbox"/> 7. Suburb E</p> <p><input type="checkbox"/> 8. Etc.</p> <p><input type="checkbox"/> 9. Other city in state (If #9 is checked, specify name of city.)</p> | <p style="text-align: center;"><i>Answer for residents of planning region only</i></p> <p>..... Block number (Example: If house number is 51, enter 50. If it is 512, enter 500. If it is 5123, enter 5100, etc. If it is less than 10, enter "X".)</p> <p>Even Odd</p> <p><input type="checkbox"/> 1. <input type="checkbox"/> 2. Is house number even or odd?</p> <p>..... RFD Town (Show RFD and town only if applicable)</p> |
|---|---|

- B. Type of case:** Check most appropriate box.
- ☐ 1. Medical
- ☐ 2. Surgical
- ☐ 3. Surgical patient, not operated
- ☐ 4. Admitted primarily for mental, psychoneurotic, or personality disorder
- ☐ 5. Maternity
- C. Discharge data:** On discharge, this patient went to
- ☐ 1. Own, friend's, or relative's home
- ☐ 2. Nursing home
- ☐ 3. Facility for well aged
- ☐ 4. Other general hospital
- ☐ 5. Tuberculosis hospital
- ☐ 6. Mental hospital
- ☐ 7. Other facility (specify type.)
.....
- ☐ 8. Deceased
- ☐ 9. Unknown
- D. Patient's sex:**
- ☐ 1. Male
- ☐ 2. Female
- E. Patient's race:**
- ☐ 1. White
- ☐ 2. Negro
- ☐ 3. Other
- F. Choice of physician made by:**
- ☐ 1. Patient (i.e., personal physician)
- ☐ 2. Hospital (i.e., assigned physician)

- G. Patient's discharge date:**
..... 19..
- H. Length of stay:**
..... Nearest whole days
- I. Patient's age:**
..... Years (at last birthday)
- ☐ 1. Check here for infants under 1 year
- J. Admitting physician:**
..... Patient's physician
- K. Type of accommodation:** Enter number of days in each type of room
- One-bed room
- Two-bed room
- Three- or four-bed room
- Over four beds
- L. Method of payment:** Enter amount billed to each source (to nearest dollar)
- Private pay
- Blue Cross
- Commercial insurance
- State or local government welfare agencies
- Kerr-Mills
- Private charitable organization(s)
- Free (i.e., enter approximate value of free care)
- Other
- Total bill (i.e., the sum of the amounts listed above)

THE OUTPATIENT INFORMATION FORM

The outpatient questionnaire enables planning agencies to determine the area served by each outpatient department and to put together a profile of the patients utilizing ambulatory facilities.

The outpatient information form requests data on patient origin, age, sex, race, and method of payment. It also seeks information on clinics attended and disposition of case. The latter should be helpful in determining what additional load is placed on inpatient facilities of hospitals maintaining outpatient departments.

The proposed outpatient survey covers both indigent and non-indigent patients attending scheduled clinics and patients utilizing emergency rooms. It should cover a period of time sufficient to gather information on at least one day's operation of each type of regularly scheduled clinic. One form should be completed for each patient who visits an outpatient department on any given day during the survey period. Repeat visits during the survey period can be identified by sorting on question I. The head of the outpatient department at each facility should be consulted to determine the number of questionnaires needed

Outpatient Information

Patient's name..... Case #.....

This portion of the questionnaire must be detached before returning to survey staff

| | |
|--|--|
| <p>Complete one copy of this form for each outpatient or emergency patient treated between 19.. and 19.. Complete one form for each patient treated on a given day. Return this form to by 19..</p> <p>For further information, call this number</p> | <p style="text-align: center;"><i>This space for staff use only</i></p> <p style="text-align: center;">Facility #</p> <p>Form # Census tract</p> |
|--|--|

| | |
|---|--|
| <p>A. Location of patient's home:</p> <p><input type="checkbox"/> 1. Out of State</p> <p><input type="checkbox"/> 2. Central city</p> <p><input type="checkbox"/> 3. Suburb A</p> <p><input type="checkbox"/> 4. Suburb B</p> <p><input type="checkbox"/> 5. Suburb C</p> <p><input type="checkbox"/> 6. Suburb D</p> <p><input type="checkbox"/> 7. Suburb E</p> <p><input type="checkbox"/> 8. Etc.</p> <p><input type="checkbox"/> 9. Other city in State (If #9 is checked, specify name of city.)</p> | <p><i>Answer for residents of planning region only</i></p> <p>..... Street name</p> <p>..... Block number (Example: If house number is 51, enter 50. If it is 512, enter 500. If it is 5123, enter 5100, etc. If it is less than 10, enter "X".)</p> <p>Even Odd</p> <p><input type="checkbox"/> 1. <input type="checkbox"/> 2. Is house number even or odd?</p> <p>..... RFD. Town</p> <p style="text-align: center;">(Show RFD and town only if applicable)</p> |
|---|--|

| | |
|--|--|
| <p>B. Clinics attended:</p> <p><input type="checkbox"/> 1. Tumor</p> <p><input type="checkbox"/> 2. Heart</p> <p><input type="checkbox"/> 3. Chest</p> <p><input type="checkbox"/> 4. Orthopedic</p> <p><input type="checkbox"/> 5. Mental health</p> <p><input type="checkbox"/> 6. Well baby</p> <p><input type="checkbox"/> 7. Prenatal</p> <p><input type="checkbox"/> 8. EENT</p> <p><input type="checkbox"/> 9. GYN</p> <p><input type="checkbox"/> 10. VD</p> <p><input type="checkbox"/> 11. Evaluation and followup</p> <p><input type="checkbox"/> 12. Dental</p> <p><input type="checkbox"/> 13. Dermatological</p> <p><input type="checkbox"/> 14. Endocrine</p> <p><input type="checkbox"/> 15. Neurological</p> <p><input type="checkbox"/> 16. Epileptic</p> <p><input type="checkbox"/> 17. Physical medicine</p> <p><input type="checkbox"/> 18. Podiatry</p> <p><input type="checkbox"/> 19. Medical diagnostic</p> <p><input type="checkbox"/> 20. Rheumatological</p> <p><input type="checkbox"/> 21. Surgical</p> <p><input type="checkbox"/> 22. Other (Specify below).</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> | <p>C. Patient's age:</p> <p>..... Years (at last birthday)</p> <p><input type="checkbox"/> 1. Check here for infants under 1 year</p> <p>D. Patient's sex:</p> <p><input type="checkbox"/> 1. Male</p> <p><input type="checkbox"/> 2. Female</p> <p>E. Patient's race:</p> <p><input type="checkbox"/> 1. White</p> <p><input type="checkbox"/> 2. Negro</p> <p><input type="checkbox"/> 3. Other</p> <p>F. Type of patient:</p> <p><input type="checkbox"/> 1. Emergency</p> <p><input type="checkbox"/> 2. Clinic</p> <p><input type="checkbox"/> 3. Private referred</p> <p>G. Disposition of case:</p> <p><input type="checkbox"/> 1. Admitted as inpatient</p> <p><input type="checkbox"/> 2. Inpatient admission recommended or scheduled</p> <p><input type="checkbox"/> 3. Other</p> <p>H. Method of payment:</p> <p><input type="checkbox"/> 1. Full pay</p> <p><input type="checkbox"/> 2. Part pay</p> <p><input type="checkbox"/> 3. Free</p> <p>I. Previous visits:</p> <p><input type="checkbox"/> 1. Check here if patient has been treated here previously during survey period</p> |
|--|--|

THE LONG-TERM CARE FACILITY INFORMATION FORM

The final suggested survey questionnaire is designed to assemble basic data about long-term care facilities. These include nursing homes, chronic disease hospitals, convalescent facilities and the like. A general hospital which owns or operates a long-term care unit should complete the long-term care facility information questionnaire for the long-term unit only.

This form solicits from each facility information on the types of patients accepted, coordinated relationships with hospitals through formal and

informal agreements, availability of professional personnel, and present and projected bed capacity. It also seeks information on the number of patients by major disability classifications, number of patients by age and sex, and other data.

Additional survey procedures may be found in Public Health Service Publication No. 454 "Guide to Making a Survey of Patients Receiving Nursing and Personal Care." (20) This publication is out of print, but may be available in local libraries.

Long-Term Care Facility Information

Please complete one copy of this questionnaire and return it to _____ by _____ 19__
For further information, call this number _____

This space for staff use only

Facility # _____

A. Types of cases accepted:

| Accepted | Not Accepted | |
|--------------------------|--------------------------|--|
| 1. | 2. | |
| <input type="checkbox"/> | <input type="checkbox"/> | Male |
| <input type="checkbox"/> | <input type="checkbox"/> | Female |
| <input type="checkbox"/> | <input type="checkbox"/> | Couples |
| <input type="checkbox"/> | <input type="checkbox"/> | White |
| <input type="checkbox"/> | <input type="checkbox"/> | Negro |
| <input type="checkbox"/> | <input type="checkbox"/> | Oriental |
| <input type="checkbox"/> | <input type="checkbox"/> | Other nonwhite |
| <input type="checkbox"/> | <input type="checkbox"/> | Age under 20 |
| <input type="checkbox"/> | <input type="checkbox"/> | Age 20-65 |
| <input type="checkbox"/> | <input type="checkbox"/> | Age over 65 |
| <input type="checkbox"/> | <input type="checkbox"/> | Mentally retarded |
| <input type="checkbox"/> | <input type="checkbox"/> | Mentally ill |
| <input type="checkbox"/> | <input type="checkbox"/> | Senile |
| <input type="checkbox"/> | <input type="checkbox"/> | Spastic |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcoholic |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug addicted |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetic |
| <input type="checkbox"/> | <input type="checkbox"/> | Tubercular |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Blind |
| <input type="checkbox"/> | <input type="checkbox"/> | Deaf |
| <input type="checkbox"/> | <input type="checkbox"/> | Postoperative |
| <input type="checkbox"/> | <input type="checkbox"/> | Incontinent (feces) |
| <input type="checkbox"/> | <input type="checkbox"/> | Incontinent (urine) |
| <input type="checkbox"/> | <input type="checkbox"/> | Bedfast |
| <input type="checkbox"/> | <input type="checkbox"/> | Ambulatory (unassisted) |
| <input type="checkbox"/> | <input type="checkbox"/> | Ambulatory (assisted) |
| <input type="checkbox"/> | <input type="checkbox"/> | Confined to wheelchair |
| <input type="checkbox"/> | <input type="checkbox"/> | Patients requiring intravenous feeding |
| <input type="checkbox"/> | <input type="checkbox"/> | "Noisy" |
| <input type="checkbox"/> | <input type="checkbox"/> | Welfare cases |

B. Coordination with hospitals:

Indicate which of the following functions or activities are carried out through one or more agreements with a hospital or hospitals.

| Written Agreement | Informal or Oral Agreement | No Program | |
|--------------------------|----------------------------|--------------------------|--|
| 1. | 2. | 3. | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Consultation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sharing personnel |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hospital helps to train home's staff |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hospital performs laboratory work for home |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Home assists hospitals in geriatric training of hospital staff, nurses, and/or professional students |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hospital provides acute care for patients of home |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other (specify below) |
| | | | _____ |
| | | | _____ |

C. Professional personnel:

| Full Time | Part Time | On Call | None | |
|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------------|
| 1. | 2. | 3. | 4. | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Physician(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Registered nurse(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Licensed practical nurse(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dentist(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dietitian(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Physical therapist(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Occupational therapist(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Social worker(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Clergyman (men) |

D. Capacity: (If none, enter "X". Complete all items.)

---- Number of existing beds

---- Number of beds currently under construction

---- Number of additional beds planned, for construction by ____ 19__ (5 yrs.) (Excluding beds now under construction)

E. Patient census, ____ 19__ (If none, enter "X")

---- Total number of patients

---- Number of bedfast patients

---- Number of patients confined to wheelchair.

---- Number of fully ambulatory patients

---- Number of patients who are ambulatory with assistance (i.e. crutch, walker)

F. Special data for month of ____ 19__ (If none, enter "X")

---- Number of patients transferred from this facility to a hospital for acute care during the last month

---- Number of new patients transferred to this facility from hospitals during the last month

---- Number of patients treated in an infirmary unit at this facility during the last month

---- Number of patients who were examined or treated by a physician during the last month

G. Patients' age and sex: (If none, enter "X")

Enter data for patients in this facility on ____ 19__

| Total | Male | Female | |
|-------|-------|--------|----------|
| ----- | ----- | ----- | Under 15 |
| ----- | ----- | ----- | 15-44 |
| ----- | ----- | ----- | 45-64 |
| ----- | ----- | ----- | 65-74 |
| ----- | ----- | ----- | 75-84 |
| ----- | ----- | ----- | 85+ |

Appendix II

Tabulation of Data

The tables presented in this appendix are examples of the kinds of tabulations that might be made from the data collected from survey questionnaires and other sources. These sample tables are incomplete in many instances, and the term "etc." has been used to indicate that the tabulation should be carried out further if the data permit.

Each table is accompanied by a statement showing the sources of the data, the questions answered by the table, and the way the table may be used. This has been done to emphasize the basic philosophy that statistics should not be collected unless a use for them can be foreseen.

Table 1.—Number and Percent of Reporting Hospitals and Beds in Reporting Hospitals, by Services Provided

| Service | Reporting Hospitals | | | | Beds | | | |
|------------------------|--------------------------|---------------------------|---------|---------------------------|--------------------------------|------------------------------|---------|--|
| | Number providing service | Total hospitals reporting | Percent | Percent providing service | In hospitals providing service | Total in reporting hospitals | Percent | Percent in hospitals providing service |
| Laboratory services | | | | | | | | |
| Animal laboratory | | | 100 | | | | 100 | |
| Autopsy | | | 100 | | | | 100 | |
| Bacteriology | | | 100 | | | | 100 | |
| Biochemistry | | | 100 | | | | 100 | |
| Blood bank | | | 100 | | | | 100 | |
| Bone bank | | | 100 | | | | 100 | |
| Eye bank | | | 100 | | | | 100 | |
| Hematology | | | 100 | | | | 100 | |
| Histology | | | 100 | | | | 100 | |
| Parasitology | | | 100 | | | | 100 | |
| Serology | | | 100 | | | | 100 | |
| Other | | | 100 | | | | 100 | |
| Radiological services | | | | | | | | |
| Diagnostic X-ray | | | 100 | | | | 100 | |
| Fluoroscopy | | | 100 | | | | 100 | |
| Therapy | | | 100 | | | | 100 | |
| Radioisotope | | | | | | | | |
| Diagnostic tracer | | | 100 | | | | 100 | |
| External bomb | | | 100 | | | | 100 | |
| Radium | | | 100 | | | | 100 | |
| Therapy, general | | | 100 | | | | 100 | |
| Therapy, interstitial | | | 100 | | | | 100 | |
| Therapy, intracavitary | | | 100 | | | | 100 | |
| Other | | | 100 | | | | 100 | |
| Etc. | | | 100 | | | | 100 | |

Sources:

1. Hospital information questionnaire, questions A through H.

Questions answered:

1. What services are provided in all hospitals?
2. What services are infrequently provided?
3. What services are not provided in any hospital?
4. What proportion of all beds are in hospitals in which the listed services are available?

Use:

1. Can help to uncover cases of unnecessary duplication of services.
2. Assists in pointing out gaps in available services.

Table 2.—Number and Percent of Reporting Hospitals Maintaining Selected Committees

| Type of committee | Number with committee | Total hospitals reporting | Percent | Percent with committee |
|-------------------|-----------------------|---------------------------|---------|------------------------|
| Admission | | | | |
| Credentials | | | | |
| Discharge | | | | |
| Medical records | | | | |
| Tissue | | | | |
| Utilization | | | | |
| Planning | | | | |

Sources:

1. Hospital information questionnaire, question 1.

Questions answered:

1. What proportion of hospitals have taken formal steps to control utilization, promote high quality care and facilitate better planning?

Use:

1. Suggests to hospitals steps which they can take to influence utilization and facilitate better planning.

Table 3.—Number and Percent of Reporting Hospitals Maintaining Selected Services on a 24-Hour Basis

| 24-hour staffed service | Number with service | Total hospitals reporting | Percent | Percent with service |
|------------------------------|---------------------|---------------------------|---------|----------------------|
| Delivery room | | | | |
| Emergency room | | | | |
| Surgery | | | | |
| X-ray | | | | |
| Laboratory | | | | |
| Physician for emergency care | | | | |

Sources:

1. Hospital information questionnaire, question J.

Questions answered:

1. In how many hospitals are the listed services staffed on a full-time basis?
2. To what extent are hospitals prepared to meet emergencies?

Use:

1. May indicate gaps in available services.
2. Provides some indication of quality and continuity of care.

Table 4.—*Number of Reporting Hospitals with Coordinated Programs, by Type of Coordination and Type of Agreement*

| Type of coordination | Total hospitals reporting | Percent | Number of hospitals | | | Percent with agreements |
|--|---------------------------|---------|-----------------------|-------------------|----------------|-------------------------|
| | | | Total with agreements | Written agreement | Oral agreement | |
| <i>Coordination with health departments</i> | | | | | | |
| Housing for labs and offices | | 100 | | | | |
| Operation of health department lab | | 100 | | | | |
| Sharing of personnel | | 100 | | | | |
| Cancer registry | | 100 | | | | |
| Other | | 100 | | | | |
| <i>Coordination with nursing homes</i> | | | | | | |
| Providing consultation | | 100 | | | | |
| Sharing of personnel | | 100 | | | | |
| Training home's staff | | 100 | | | | |
| Performing lab work for home | | 100 | | | | |
| Geriatric training for hospital's staff and/or professional students | | 100 | | | | |
| Providing acute care for home's patients | | 100 | | | | |
| Other | | 100 | | | | |
| <i>Coordination with other facilities</i> | | | | | | |
| Joint recruiting of personnel | | 100 | | | | |
| Joint purchasing | | 100 | | | | |
| Training of non-professional hospital personnel | | 100 | | | | |
| Sharing of dietary department | | 100 | | | | |
| Joint cobalt or cesium unit | | 100 | | | | |
| Joint use of artificial kidney | | 100 | | | | |
| Sharing of personnel | | 100 | | | | |
| Joint use of iron lung | | 100 | | | | |
| Joint use of EEG | | 100 | | | | |
| Joint use of X-ray therapy | | 100 | | | | |
| Other | | 100 | | | | |

Sources:

1. Hospital information questionnaire, questions K through M.

Questions answered:

1. What kinds of joint programs and cooperative efforts are carried out by hospitals?
2. How many hospitals participate in each type of joint or cooperative activity listed?

Use:

1. Suggests types of activities in which facilities can engage to facilitate better coordination.
2. May indicate that a greater degree of coordination is necessary or possible and consequently create greater support for the planning effort.

Table 5.—Utilization of Inpatient Services, by Hospital

| Class of data | All reporting hospitals | Hospital A | Hospital B | Hospital C | Hospital D | Etc. |
|---|-------------------------|------------|------------|------------|------------|------|
| <i>Inpatient data (excluding newborn)</i> | | | | | | |
| Number of admissions | | | | | | |
| Number of discharges including deaths | | | | | | |
| Total inpatient days | | | | | | |
| Total days of care rendered for discharged patients | | | | | | |
| <i>Newborn data</i> | | | | | | |
| Number of live births | | | | | | |
| Number of stillbirths | | | | | | |
| Number of abortions | | | | | | |
| Total newborn days | | | | | | |

Sources:

1. Hospital information questionnaire, question N.

Questions answered:

1. What volume of services is rendered annually by each hospital?

Use:

1. Facilitates the calculation of each hospital's occupancy in a uniform and comparable manner.
2. Permits the calculation of the overall occupancy rate for all facilities.
3. Helps to determine how representative of a full year's experience are data gathered in the inpatient survey.
4. Can be used in connection with patient origin data to derive measures of utilization needed for determining bed need (i. e., patient days/population).
5. Demonstrates to the public and to community leaders the extent of services rendered by hospitals.

Table 6.—Utilization of Selected Services by Inpatients and Outpatients, by Hospital and Type of Service

| Service | All reporting hospitals | Hospital A | Hospital B | Hospital C | Hospital D | Etc. |
|--|-------------------------|------------|------------|------------|------------|------|
| Number of cobalt or cesium treatments | | | | | | |
| Other deep therapy | | | | | | |
| Radium and radioisotope therapy procedures | | | | | | |
| Number of diagnostic radioisotope studies | | | | | | |
| Number of open heart operations | | | | | | |
| Number of artificial kidney procedures | | | | | | |
| Number of diagnostic X-rays | | | | | | |
| Number of operations (total) | | | | | | |
| "Major" operations | | | | | | |
| "Minor" operations | | | | | | |
| Number of EEG's | | | | | | |
| Number of EKG's | | | | | | |
| Number of physical therapy treatments | | | | | | |

Sources:

1. Hospital information questionnaire, question O.

Questions answered:

1. What is the annual volume of specialized services and procedures?
2. What is the contribution of each hospital to the total community output of such services and procedures?

Use:

1. Helps to develop indices of need for expensive, highly specialized and low-volume services.
2. Assists in discovering evidence of unnecessary duplication of such services.

Table 7.—Number of Outpatient Visits and Inpatient Admissions of Outpatients, by Hospital and Patient Classification

| Hospital and type of data | All reported outpatients | Emergency | Clinic | Physician referred |
|---------------------------|--------------------------|-----------|--------|--------------------|
| All hospitals Visits | | | | |
| Admissions | | | | |
| Hospital A Visits | | | | |
| Admissions | | | | |
| Hospital B Visits | | | | |
| Admission | | | | |
| Hospital C Visits | | | | |
| Admissions | | | | |
| Hospital D Visits | | | | |
| Admissions | | | | |
| Etc. | | | | |

Sources:

1. Hospital information questionnaire, question P.

Questions answered?

1. What is the annual volume of outpatient service?
2. What is the contribution of each hospital to the total volume of outpatient service?
3. How many of each type of patient use outpatient departments?
4. To what extent do outpatient departments contribute to inpatient admissions in hospitals having such departments?

Use:

1. Shows the extent to which OPD's serve as sources of admission.
2. Helps to determine how representative of a full year's experience are data gathered in the outpatient survey.
3. Indicates the extent to which OPD's are used for physician office visits by indigents.
4. Indicates the extent to which physicians refer private patients for diagnostic services.

Table 8.—Number of Rooms and Number of Beds in General Hospitals, by Hospital and Room Capacity

| | All reporting hospitals | Hospital A | Hospital B | Hospital C | Etc. |
|--------------------------|-------------------------|------------|------------|------------|------|
| <i>1-bed rooms</i> | | | | | |
| Number of Beds | | | | | |
| Number of Rooms | | | | | |
| <i>2-bed rooms</i> | | | | | |
| Number of Beds | | | | | |
| Number of Rooms | | | | | |
| <i>3- or 4-bed rooms</i> | | | | | |
| Number of Beds | | | | | |
| Number of Rooms | | | | | |
| <i>Over 4-bed rooms</i> | | | | | |
| Number of Beds | | | | | |
| Number of Rooms | | | | | |

Sources:

1. Hospital information questionnaire, question Q.

Questions answered:

1. What is the distribution of accommodations in nursing units, by bed capacity?
2. How does this distribution vary among hospitals?

Use:

1. A large proportion of ward-type accommodations may prove to be some indication of degree of obsolescence.
2. When combined with figures on occupancy by type of accommodation, may indicate that redistribution of beds among private, semi-private and ward-type facilities is desirable.

**Table 9.—Number of Available Places and Number of Students in Hospital Training Programs,
by Type of Training and Hospital**

| Type of training and hospital | Affiliating students | Hospital-operated school | | | |
|-------------------------------|-------------------------|--------------------------|---------|----------|--------------------------|
| | | Capacity | Percent | Students | Percent places filled |
| Dietetics | | | 100 | | |
| All reporting hospitals | | | 100 | | |
| Hospital A | | | 100 | | |
| Hospital B | | | 100 | | |
| Hospital C | | | 100 | | |
| Etc. | | | 100 | | |
| Librarianship | | | 100 | | |
| All reporting hospitals | | | 100 | | |
| Hospital A | | | 100 | | |
| Hospital B | | | 100 | | |
| Hospital C | | | 100 | | |
| Etc. | | | 100 | | |
| Medical students | | | 100 | | |
| All reporting hospitals | | | 100 | | |
| Hospital A | | | 100 | | |
| Hospital B | | | 100 | | |
| Hospital C | | | 100 | | |
| Etc. | | | 100 | | |
| Medical records | | | 100 | | |
| All reporting hospitals | | | 100 | | |
| Hospital A | | | 100 | | |
| Hospital B | | | 100 | | |
| Hospital C | | | 100 | | |

Table 9.—Number of Available Places and Number of Students in Hospital Training Programs, by Type of Training and Hospital—Continued

| Type of training and hospital | Affiliating students | Hospital-operated school | | | |
|--------------------------------|----------------------|--------------------------|---------|----------|-----------------------|
| | | Capacity | Percent | Students | Percent places filled |
| Clinical Laboratory Technology | | | 100 | | |
| All reporting hospitals | | | 100 | | |
| Hospital A | | | 100 | | |
| Hospital B | | | 100 | | |
| Hospital C | | | 100 | | |
| Etc. | | | 100 | | |
| Registered Nurse | | | 100 | | |
| All reporting hospitals | | | 100 | | |
| Hospital A | | | 100 | | |
| Hospital B | | | 100 | | |
| Hospital C | | | 100 | | |
| Etc. | | | 100 | | |
| Licensed Practical Nurse | | | 100 | | |
| All reporting hospitals | | | 100 | | |
| Hospital A | | | 100 | | |
| Hospital B | | | 100 | | |
| Hospital C | | | 100 | | |
| Etc. | | | 100 | | |
| Etc. | | | 100 | | |

Sources:

1. Hospital information questionnaire, question R.

Questions answered:

1. Which hospitals are engaged in educational activities?
2. What kinds of educational programs are being conducted in the planning region?

Use:

1. Helps to assess the need for various kinds of hospital-operated training programs.
2. Assists in gaining agreement on the future roles of facilities with respect to educational activities.

Table 10.—Number of Residencies and Residents, by Specialty and Hospital

| Type of residency and hospital | Residencies | Percent | Residents | Percent places filled |
|--------------------------------|-------------|---------|-----------|-----------------------|
| Dermatology and Syphilology | | 100 | | |
| All reporting hospitals | | 100 | | |
| Hospital A | | 100 | | |
| Hospital B | | 100 | | |
| Hospital C | | 100 | | |
| Etc. | | 100 | | |
| Internal Medicine | | 100 | | |
| All reporting hospitals | | 100 | | |
| Hospital A | | 100 | | |
| Hospital B | | 100 | | |
| Hospital C | | 100 | | |
| Etc. | | 100 | | |
| Allergy | | 100 | | |
| All reporting hospitals | | 100 | | |
| Hospital A | | 100 | | |
| Hospital B | | 100 | | |
| Hospital C | | 100 | | |
| Etc. | | 100 | | |
| Gastroenterology | | 100 | | |
| All reporting hospitals | | 100 | | |
| Hospital A | | 100 | | |
| Hospital B | | 100 | | |
| Hospital C | | 100 | | |
| Etc. | | 100 | | |

Table 10.—Number of Residencies and Residents, by Specialty and Hospital—Continued

| Type of residency and hospital | Residencies | Percent | Residents | Percent places filled |
|--------------------------------|-------------|---------|-----------|-----------------------|
| Pulmonary Diseases | | 100 | | |
| All reporting hospitals | | 100 | | |
| Hospital A | | 100 | | |
| Hospital B | | 100 | | |
| Hospital C | | 100 | | |
| Etc. | | 100 | | |
| Neurology | | 100 | | |
| All reporting hospitals | | 100 | | |
| Hospital A | | 100 | | |
| Hospital B | | 100 | | |
| Hospital C | | 100 | | |
| Etc. | | 100 | | |
| Pediatrics | | 100 | | |
| All reporting hospitals | | 100 | | |
| Hospital A | | 100 | | |
| Hospital B | | 100 | | |
| Hospital C | | 100 | | |
| Etc. | | 100 | | |
| Etc. | | 100 | | |

Sources:

1. Hospital information questionnaire, question T.

Questions answered:

1. Which hospitals offer residency training?
2. What kinds of residency programs are available?
3. Are existing residency programs being utilized as fully as possible?

Use:

1. Helps to assess the need for additional residency programs.
2. Assists in gaining agreement on the future roles of facilities with respect to operating residency training programs.
3. May provide a rough index of quality of care.

Table 11.—Number of Internships and Number of Interns, by Hospital

| Hospital | Internships | Percent | Interns | Percent filled |
|-------------------------|-------------|---------|---------|----------------|
| All reporting hospitals | | 100 | | |
| Hospital A | | 100 | | |
| Hospital B | | 100 | | |
| Hospital C | | 100 | | |
| Hospital D | | 100 | | |
| Hospital E | | 100 | | |
| Hospital F | | 100 | | |
| Hospital G | | 100 | | |
| Hospital H | | 100 | | |
| Hospital I | | 100 | | |
| Hospital J | | 100 | | |
| Hospital K | | 100 | | |
| Hospital L | | 100 | | |
| Hospital M | | 100 | | |
| Hospital N | | 100 | | |
| Hospital O | | 100 | | |
| Hospital P | | 100 | | |
| Etc. | | 100 | | |

Sources:

1. Hospital information questionnaire, question S.

Questions answered:

1. Which hospitals have internship programs?
2. To what extent are these programs being utilized?

Use:

1. Helps the planning agency to identify hospitals which may qualify to operate specialized services.

Table 12.—Past, Present and Projected Bed Complement, by Hospital

| Hospital | Beds in operation 5 years ago 19— | Beds currently in operation 19— | Beds currently under construction 19— | Projected bed complement in 5 years 19— |
|-------------------------|-----------------------------------|---------------------------------|---------------------------------------|---|
| All reporting hospitals | | | | |
| Hospital A | | | | |
| Hospital B | | | | |
| Hospital C | | | | |
| Hospital D | | | | |
| Hospital E | | | | |
| Hospital F | | | | |
| Hospital G | | | | |
| Hospital H | | | | |
| Hospital I | | | | |
| Hospital J | | | | |
| Hospital K | | | | |
| Hospital L | | | | |
| Hospital M | | | | |
| Hospital N | | | | |
| Hospital O | | | | |
| Hospital P | | | | |
| Hospital Q | | | | |
| Hospital R | | | | |
| Hospital S | | | | |
| Etc. | | | | |

Sources:

1. Hospital information questionnaire, question U.

Questions answered:

1. How many beds are currently in use?
2. How many beds are currently under construction?
3. Which facilities are planning construction work to be completed within the next 5 years?
4. Which facilities have added to their capacity during the last 5 years?
5. How many additional beds are planned?

Use:

1. Provides an inventory of existing beds.
2. Alerts the planning agency to each hospital's future plans for expansion plans.
3. Shows short-term trends in total community bed capacity.
4. When compared with bed need estimates, may be used to judge the adequacy of present and planned capacity.

Table 13.—*Bed Complement, by Hospital and Clinical Service*

| Clinical services | Hospital A | Hospital B | Hospital C | Etc. |
|-----------------------|------------|------------|------------|------|
| Total reported beds | | | | |
| Medical and surgical | | | | |
| Obstetrical | | | | |
| Convalescent | | | | |
| Communicable disease | | | | |
| Chronic disease | | | | |
| Tuberculosis | | | | |
| Genitourinary | | | | |
| Gynecological | | | | |
| Orthopedic | | | | |
| Psychiatric | | | | |
| Pediatric | | | | |
| Other | | | | |
| Bassinets for newborn | | | | |

Sources:

1. Hospital information questionnaire, question U.

Questions answered:

1. How many beds does each hospital have?
2. How extensively is each hospital broken down into clinical departments?

Use:

1. Provides an inventory of existing beds.
2. When compared with need estimates, will show whether existing building plans and programs appear to be adequate.
3. Will show the extent to which flexibility in use of beds is precluded by the existence of specialized clinical units within hospitals.
4. Can be used to determine the extent to which beds are concentrated in facilities of small and uneconomical size.

Table 14.—Number of Reported Beds, by Hospital Ownership and Clinical Service

| Clinical service | All hospitals | Proprietary | Federal Government | State | County | Municipal | City and county | District |
|-----------------------|---------------|-------------|--------------------|-------|--------|-----------|-----------------|----------|
| Total reported beds | | | | | | | | |
| Medical and surgical | | | | | | | | |
| Obstetrical | | | | | | | | |
| Convalescent | | | | | | | | |
| Communicable disease | | | | | | | | |
| Chronic disease | | | | | | | | |
| Tuberculosis | | | | | | | | |
| Genitourinary | | | | | | | | |
| Gynecological | | | | | | | | |
| Orthopedic | | | | | | | | |
| Psychiatric | | | | | | | | |
| Pediatric | | | | | | | | |
| Other | | | | | | | | |
| Bassinets for newborn | | | | | | | | |

Sources:

1. Hospital information questionnaire, question U.
2. State plans.
3. Guide issue of *Hospitals*.

Questions answered:

1. How many beds are available in each type of facility?
2. Which classes of facilities offer the most complete range of services?

Use:

1. Provides an inventory of beds by ownership category.

Table 15.—*Number of Reported Beds, by Hospital Location and Clinical Service*

| Clinical service | All hos- pitals | Central city | | | Suburb A | Suburb B | Etc. | Rest of region |
|-----------------------|--------------------|-------------------|-------------------|------|----------|----------|------|-------------------|
| | | Census tract 1 | Census tract 2 | Etc. | | | | |
| Total reported beds | | | | | | | | |
| Medical and surgical | | | | | | | | |
| Obstetrical | | | | | | | | |
| Convalescent | | | | | | | | |
| Communicable disease | | | | | | | | |
| Chronic disease | | | | | | | | |
| Tuberculosis | | | | | | | | |
| Genitourinary | | | | | | | | |
| Gynecological | | | | | | | | |
| Orthopedic | | | | | | | | |
| Psychiatric | | | | | | | | |
| Pediatric | | | | | | | | |
| Other | | | | | | | | |
| Bassinets for newborn | | | | | | | | |

Sources:

1. Hospital information questionnaire, question U.
2. State plans.
3. Guide issue of *Hospitals*.

Questions answered:

1. How many beds are there in each area?
2. What range of clinical services is offered in each area?

Use:

1. Provides an inventory of beds by location of facility.

Table 16.—Past, Present and Projected Bed Complement, by Clinical Service

| Clinical service | Beds in operation 5 years ago 19— | Beds currently in operation 19— | Beds currently under construction 19— | Projected bed complement in 5 years 19— |
|-----------------------|-----------------------------------|---------------------------------|---------------------------------------|---|
| Total reported beds | | | | |
| Medical | | | | |
| Surgical | | | | |
| Obstetrical | | | | |
| Convalescent | | | | |
| Communicable disease | | | | |
| Chronic disease | | | | |
| Tuberculosis | | | | |
| Genitourinary | | | | |
| Gynecological | | | | |
| Orthopedic | | | | |
| Psychiatric | | | | |
| Pediatric | | | | |
| Other | | | | |
| Bassinets for newborn | | | | |

Sources:

1. Hospital information questionnaire, question U.

Questions answered:

1. What is the capacity of each clinical service?
2. What trends seem to be developing with respect to the quantity of beds available and the fraction of total beds represented by each clinical department?
3. How many beds are there likely to be in the next 5 years?

Use:

1. Provides an inventory of existing beds.
2. When compared with need estimates, will show whether existing building plans and programs appear to be adequate.

Table 17.—Past and Prospective Amount of Funds for Construction, by Source

| Sources of funds | Funds raised last 5 years | Funds to be raised next 5 years |
|-------------------------------------|------------------------------|------------------------------------|
| Total, all sources | \$ | \$ |
| Hospital funds | \$ | \$ |
| Corporate gifts | \$ | \$ |
| Private gifts | \$ | \$ |
| Hospital employees | \$ | \$ |
| Medical staff | \$ | \$ |
| Trustees | \$ | \$ |
| Hospital auxiliary | \$ | \$ |
| Major individual gifts | \$ | \$ |
| Public subscriptions | \$ | \$ |
| Other private gifts | \$ | \$ |
| Foundations | \$ | \$ |
| Federal grants | \$ | \$ |
| State and local government grants | \$ | \$ |
| Grants from affiliated church group | \$ | \$ |
| Loans from affiliated church group | \$ | \$ |
| Commercial loans | \$ | \$ |
| Bond issues | \$ | \$ |
| Tax revenues | \$ | \$ |
| Other sources | \$ | \$ |

Sources:

1. Hospital information questionnaire, question V.

Questions answered:

1. How much money has been assembled in the immediate past for hospital construction, and from what sources?
2. How much expenditure is planned and how will the money be raised?

Use:

1. Helps to show hospitals whether aggregate construction plans are reasonable from a financial standpoint.

Table 18.—Number of Discharges, by *Place of Residence and Hospital**

| Patients' place of residence | Total all hospitals | Hospital #1 | Hospital #2 | Hospital #3 | Hospital #4 | Hospital #5 | Hospital #6 | Etc. |
|------------------------------|---------------------|-------------|-------------|-------------|-------------|-------------|-------------|------|
| Central city(s) | | | | | | | | |
| Census tract 1 | | | | | | | | |
| Census tract 2 | | | | | | | | |
| Census tract 3 | | | | | | | | |
| Census tract 4 | | | | | | | | |
| Etc. | | | | | | | | |
| Suburbs | | | | | | | | |
| Suburb A, total | | | | | | | | |
| Census tract 1 | | | | | | | | |
| Census tract 2 | | | | | | | | |
| Etc. | | | | | | | | |
| Suburb B | | | | | | | | |
| Suburb C | | | | | | | | |
| Suburb D | | | | | | | | |
| Etc. | | | | | | | | |
| Remainder of region | | | | | | | | |
| RFD 1 | | | | | | | | |
| RFD 2 | | | | | | | | |
| RFD 3 | | | | | | | | |
| Etc. | | | | | | | | |

See footnote at end of table.

Table 18.—Number of Discharges, by Place of Residence and Hospital*—Continued

| Patients' place of residence | Total, all hospitals | Hospital #1 | Hospital #2 | Hospital #3 | Hospital #4 | Hospital #5 | Hospital #6 | Etc. |
|------------------------------|----------------------|-------------|-------------|-------------|-------------|-------------|-------------|------|
| Contiguous counties | | | | | | | | |
| County 1 | | | | | | | | |
| County 2 | | | | | | | | |
| County 3 | | | | | | | | |
| County 4 | | | | | | | | |
| Elsewhere in State | | | | | | | | |
| Out of State | | | | | | | | |
| Not reported | | | | | | | | |

*Same table format may be used to show days of care rendered to discharged patients.

Sources:

1. Inpatient information questionnaire, question A.

Questions answered:

1. What territory is served by each hospital?
2. Which hospitals attract patients from all or part of the same territory?
3. Which hospitals are most important to the residents of each census tract?
4. Which hospitals draw significant numbers of patients from outside the planning region?

Use:

1. Helps each hospital to see what territory it serves.
2. Indicates which hospitals serve all or part of the same territory and consequently should work together in coordinating construction plans.
3. Helps to alert hospitals to changes in patient load that may result from population migration, urban renewal programs, etc.
4. Indicates whether patients residing outside of the planning region contribute significantly to the need for beds and services.

Table 19.—Percentage of Discharged Residents of Each Area, by Hospital

| Patients' place of residence | Total all Hospitals | Percent | Hospital #1 | Hospital #2 | Hospital #3 | Hospital #4 | Hospital #5 | Hospital #6 | Etc. |
|------------------------------|---------------------|---------|-------------|-------------|-------------|-------------|-------------|-------------|------|
| All patients, total | | 100 | | | | | | | |
| Central city(s) | | 100 | | | | | | | |
| Census tract 1 | | 100 | | | | | | | |
| Census tract 2 | | 100 | | | | | | | |
| Census tract 3 | | 100 | | | | | | | |
| Census tract 4 | | 100 | | | | | | | |
| Etc. | | 100 | | | | | | | |
| Suburbs | | 100 | | | | | | | |
| Suburb A, total | | 100 | | | | | | | |
| Census tract 1 | | 100 | | | | | | | |
| Census tract 2 | | 100 | | | | | | | |
| Etc. | | 100 | | | | | | | |
| Suburb B | | 100 | | | | | | | |
| Suburb C | | 100 | | | | | | | |
| Suburb D | | 100 | | | | | | | |
| Etc. | | 100 | | | | | | | |
| Remainder of region | | 100 | | | | | | | |
| RFD 1 | | 100 | | | | | | | |
| RFD 2 | | 100 | | | | | | | |
| RFD 3 | | 100 | | | | | | | |
| Etc. | | 100 | | | | | | | |
| Contiguous counties | | 100 | | | | | | | |
| County 1 | | 100 | | | | | | | |
| County 2 | | 100 | | | | | | | |
| County 3 | | 100 | | | | | | | |
| County 4 | | 100 | | | | | | | |
| Elsewhere in State | | 100 | | | | | | | |
| Out of State | | 100 | | | | | | | |
| Not reported | | 100 | | | | | | | |

Sources:

1. Inpatient information questionnaire, question A.

Questions answered:

1. Which hospital or hospitals are important to the residents of each census tract or other area?
2. Which hospitals share in serving the residents of any particular territory?
3. Which hospitals, if any, care for substantial proportions of persons from outside the planning region?

Use:

1. Shows hospitals that they may perform important services for the residents of particular areas even though such persons may form a small part of total patient load.
2. Serves to identify hospitals performing significant services for patients from outside the planning region.

Table 20.—Percentage of Patients Discharged from Each Hospital, by Place of Residence*

| Patients' place of residence | Total, all hospitals | Hospital #1 | Hospital #2 | Hospital #3 | Hospital #4 | Hospital #5 | Hospital #6 | Etc. |
|------------------------------|----------------------|-------------|-------------|-------------|-------------|-------------|-------------|------|
| All patients, total | | | | | | | | |
| Percent | | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Central city(s) | | | | | | | | |
| Census tract 1 | | | | | | | | |
| Census tract 2 | | | | | | | | |
| Census tract 3 | | | | | | | | |
| Census tract 4 | | | | | | | | |
| Etc. | | | | | | | | |
| Suburbs | | | | | | | | |
| Suburb A, total | | | | | | | | |
| Census tract 1 | | | | | | | | |
| Census tract 2 | | | | | | | | |
| Etc. | | | | | | | | |
| Suburb B | | | | | | | | |
| Suburb C | | | | | | | | |
| Suburb D | | | | | | | | |
| Etc. | | | | | | | | |
| Remainder of region | | | | | | | | |
| RFD 1 | | | | | | | | |
| RFD 2 | | | | | | | | |
| RFD 3 | | | | | | | | |
| Etc. | | | | | | | | |

See foot note at end of table.

Table 20.—Percentage of Patients Discharged from Each Hospital, by Place of Residence*—Cont.

| Patients' place of residence | Total, all hospitals | Hospital #1 | Hospital #2 | Hospital #3 | Hospital #4 | Hospital #5 | Hospital #6 | Etc. |
|------------------------------|----------------------|-------------|-------------|-------------|-------------|-------------|-------------|------|
| Contiguous counties | | | | | | | | |
| County 1 | | | | | | | | |
| County 2 | | | | | | | | |
| County 3 | | | | | | | | |
| County 4 | | | | | | | | |
| Etc. | | | | | | | | |
| Elsewhere in State | | | | | | | | |
| Out of State | | | | | | | | |
| Not reported | | | | | | | | |

*Same table format may be used to show percentage of days of care rendered to discharged patients.

Sources:

1. Inpatient information questionnaire, question A.

Questions answered:

1. What territory is served by each hospital?
2. Which hospitals attract patients from outside the planning region?
3. Which territory contributes the most significant proportion of each hospital's patient load?

Use:

1. Shows what geographic population groups are most important to each hospital.
2. Shows whether patients from outside the planning region contribute significantly to patient load.

Table 21.—Number of Patients by, Age, Sex and Destination After Discharge

| Destination and sex | Number of patients | | | | | | | Not re- ported |
|-----------------------------------|--------------------|----------|-------|-------|-------|-------|-----|-------------------|
| | All ages | Under 14 | 15-44 | 45-64 | 65-74 | 75-84 | 85+ | |
| All patients | | | | | | | | |
| Own, friend's, or relative's home | | | | | | | | |
| Nursing home | | | | | | | | |
| Facility for the well aged | | | | | | | | |
| Other general hospital | | | | | | | | |
| Tuberculosis hospital | | | | | | | | |
| Mental hospital | | | | | | | | |
| Other facility | | | | | | | | |
| Deceased | | | | | | | | |
| Unknown | | | | | | | | |
| Not reported | | | | | | | | |
| Male | | | | | | | | |
| Own, friend's, or relative's home | | | | | | | | |
| Nursing home | | | | | | | | |
| Facility for the well aged | | | | | | | | |
| Other general hospital | | | | | | | | |
| Tuberculosis hospital | | | | | | | | |
| Mental hospital | | | | | | | | |
| Other facility | | | | | | | | |
| Deceased | | | | | | | | |
| Unknown | | | | | | | | |
| Not reported | | | | | | | | |

Table 21.—Number of Patients by, Age, Sex and Destination After Discharge—Continued

| Destination and sex | Number of patients | | | | | | | Not re- ported |
|-----------------------------------|--------------------|----------|-------|-------|-------|-------|-----|-------------------|
| | All ages | Under 14 | 15-44 | 45-64 | 65-74 | 75-84 | 85+ | |
| Female, non-maternity | | | | | | | | |
| Own, friend's or relative's home | | | | | | | | |
| Nursing home | | | | | | | | |
| Facility for the well aged | | | | | | | | |
| Other general hospital | | | | | | | | |
| Tuberculosis hospital | | | | | | | | |
| Mental hospital | | | | | | | | |
| Other facility | | | | | | | | |
| Deceased | | | | | | | | |
| Unknown | | | | | | | | |
| Not reported | | | | | | | | |
| Female, maternity | | | | | | | | |
| Own, friend's, or relative's home | | | | | | | | |
| Nursing home | | | | | | | | |
| Facility for the well aged | | | | | | | | |
| Other general hospital | | | | | | | | |
| Tuberculosis hospital | | | | | | | | |
| Mental hospital | | | | | | | | |
| Other facility | | | | | | | | |
| Deceased | | | | | | | | |
| Unknown | | | | | | | | |
| Not reported | | | | | | | | |

Sources:

1. Inpatient information questionnaire, questions C, D, and I.

Questions answered:

1. What is the volume of discharges from general hospitals to nursing homes and other long-term facilities?
2. What is the volume of transfers of patients to other general hospitals?
3. What are the age and sex characteristics of patients transferred to other medical facilities after discharge?

Use:

1. Helps hospitals to understand the need for establishing working relationships with long-term care facilities.
2. Shows the extent to which general hospitals serve as sources of admission to long-term care facilities.
3. Assists in developing measures of need for long-term facilities by showing some of the characteristics of patients receiving long-term care.

Table 22.—*Number of Patients, by Length of Stay, Hospital and Type of Case*

[illegible]

Table 22.—Number of Patients, by Length of Stay, Hospital and Type of Case—Continued

| Hospital and type of case | All patients | Under 8 days | 8-14 days | 15-21 days | 21-30 days | 31-60 days | 61-90 days | 90 days | Not reported | Median length of stay in days |
|---------------------------|--------------|--------------|-----------|------------|------------|------------|------------|---------|--------------|-------------------------------|
| Hospital C | | | | | | | | | | |
| Medical | | | | | | | | | | |
| Surgical | | | | | | | | | | |
| Surgical, not operated | | | | | | | | | | |
| Mental | | | | | | | | | | |
| Maternity | | | | | | | | | | |
| Caesarean | | | | | | | | | | |
| Not reported | | | | | | | | | | |
| Hospital D | | | | | | | | | | |
| Medical | | | | | | | | | | |
| Surgical | | | | | | | | | | |
| Surgical, not operated | | | | | | | | | | |
| Mental | | | | | | | | | | |
| Maternity | | | | | | | | | | |
| Caesarean | | | | | | | | | | |
| Not reported | | | | | | | | | | |
| Hospital E | | | | | | | | | | |
| Medical | | | | | | | | | | |
| Etc. | | | | | | | | | | |
| Etc. | | | | | | | | | | |

Sources:

1. Inpatient information questionnaire, questions B and H.

Questions answered:

1. Is there significant variation among hospitals with respect to length of stay?
2. How does length of stay vary for different types of cases?
3. Can differences in average length of stay among hospitals (if any) be explained by differences in the proportions of various types of patients?

Use:

1. Assists in the identification of situations in which opportunity exists for reducing average length of stay.
2. Helps to "sell" hospitals on the possible advantages of home care and the need for emphasis on ambulatory and long-term facilities.

Table 23.—Number of Patients, by Age, Sex, Hospital, and Type of Case

| Type of case and hospital | All patients | | | | | Male | | | | | Female | | | | | Sex not reported |
|---------------------------|--------------|----------|-------|-----|------------------|----------|----------|-------|-----|------------------|----------|----------|-------|-----|------------------|------------------|
| | All ages | Under 14 | 15-64 | 65+ | Age not reported | All ages | Under 14 | 15-64 | 65+ | Age not reported | All ages | Under 14 | 15-64 | 65+ | Age not reported | |
| All patients | | | | | | | | | | | | | | | | |
| Medical | | | | | | | | | | | | | | | | |
| Surgical | | | | | | | | | | | | | | | | |
| Surgical, not operated | | | | | | | | | | | | | | | | |
| Psychiatric | | | | | | | | | | | | | | | | |
| Maternity | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| Not reported | | | | | | | | | | | | | | | | |
| Hospital #1 | | | | | | | | | | | | | | | | |
| Medical | | | | | | | | | | | | | | | | |
| Surgical | | | | | | | | | | | | | | | | |
| Surgical, not operated | | | | | | | | | | | | | | | | |
| Psychiatric | | | | | | | | | | | | | | | | |
| Maternity | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| Not reported | | | | | | | | | | | | | | | | |
| Hospital #2 | | | | | | | | | | | | | | | | |
| Medical | | | | | | | | | | | | | | | | |
| Surgical | | | | | | | | | | | | | | | | |
| Surgical, not operated | | | | | | | | | | | | | | | | |
| Psychiatric | | | | | | | | | | | | | | | | |
| Maternity | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| Not reported | | | | | | | | | | | | | | | | |
| Hospital #3 | | | | | | | | | | | | | | | | |
| Medical | | | | | | | | | | | | | | | | |
| Etc. | | | | | | | | | | | | | | | | |

Sources:

1. Inpatient information questionnaire, questions B, D, and I.

Questions answered:

1. What are the age and sex characteristics of patients discharged during the survey?
2. How do the characteristics of patients vary for different hospitals?

Use:

1. Shows how representative survey data are of a full year's experience when compared with summarized annual data.
2. May help in evaluating any differences among hospitals with respect to average length of stay.

Table 24.—Percent of All Patients of Each Hospital's Medical Staff Discharged During the Survey Period, by Place of Hospitalization

| Total patients and hospitals | Hospital A | Hospital B | Hospital C | Hospital D | Hospital E | Hospital F | Etc. |
|--|------------|------------|------------|------------|------------|------------|-------|
| Total patients of staff members discharged from all hospitals. | | | | | | | |
| Percent | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Percent discharged from this hospital | | | | | | | |
| Percent discharged from other hospitals | | | | | | | |
| Hospital A | XXXXX | | | | | | |
| Hospital B | | XXXXX | | | | | |
| Hospital C | | | XXXXX | | | | |
| Hospital D | | | | XXXXX | | | |
| Hospital E | | | | | XXXXX | | |
| Hospital F | | | | | | XXXXX | |
| Etc. | | | | | | | XXXXX |

Sources:

1. Hospital medical staff lists.
2. Inpatient information questionnaire, question J.

Questions answered:

1. What proportion of each hospital's medical staff's patients are sent to other hospitals?
2. Which hospitals share patient referrals on the part of physicians with multiple staff appointments?

Use:

1. May be used to point out the fact that hospitals share the task of meeting the total demands of their medical staffs?
2. Helps each hospital to understand the extent to which bed expansion can affect its occupancy as well as the case load of other hospitals through shifts in patient referrals by physicians holding multiple staff appointments.
3. Assists hospitals to understand the desirability of exchanging information with hospitals with which they share medical staff.
4. Helps hospitals to see the desirability of establishing coordinated programs with such hospitals.

Table 25.—Percent of Medical Staff With Single and Multiple Appointments, by Hospital

| Hospital | All staff physicians | | | | Specialists | | | | General practitioners | | | |
|------------|----------------------|---------|------------------------------------|---------------------------------|-------------------|---------|------------------------------------|---------------------------------|-----------------------|---------|------------------------------------|---------------------------------|
| | Total medical staff | Percent | Percent with multiple appointments | Percent with single appointment | Total specialists | Percent | Percent with multiple appointments | Percent with single appointment | Total GP's | Percent | Percent with multiple appointments | Percent with single appointment |
| Hospital A | | 100 | | | | 100 | | | | 100 | | |
| Hospital B | | 100 | | | | 100 | | | | 100 | | |
| Hospital C | | 100 | | | | 100 | | | | 100 | | |
| Hospital D | | 100 | | | | 100 | | | | 100 | | |
| Hospital E | | 100 | | | | 100 | | | | 100 | | |
| Hospital F | | 100 | | | | 100 | | | | 100 | | |
| Hospital G | | 100 | | | | 100 | | | | 100 | | |
| Hospital H | | 100 | | | | 100 | | | | 100 | | |
| Hospital I | | 100 | | | | 100 | | | | 100 | | |
| Etc. | | 100 | | | | 100 | | | | 100 | | |

Sources:

1. Hospital medical staff lists.
2. *Directory of Medical Specialists*.
3. *American Medical Directory*.

Questions answered:

1. What proportion of each hospital's medical staff has privileges at other hospitals?
2. What proportion of each hospital's medical staff has no privileges elsewhere?

Use:

1. Helps to identify those hospitals in which pressures for construction are most likely to develop in order to satisfy the medical staff's need for "sure" beds.
2. Helps hospitals to understand that, in sharing medical staff, they share patient referrals with other hospitals.

Table 26.—Number of Patients, by Place of Residence, Hospital and Type of Accommodation

| Patients' place of residence | All hospitals | | | Hospital A | | | Hospital B | | | Etc. | | |
|------------------------------|------------------|-----------------|-----------------|------------------|-----------------|-----------------|------------------|-----------------|-----------------|------------------|-----------------|-----------------|
| | 1- to 4-bed room | Over 4-bed room | Not re-reported | 1- to 4-bed room | Over 4-bed room | Not re-reported | 1- to 4-bed room | Over 4-bed room | Not re-reported | 1- to 4-bed room | Over 4-bed room | Not re-reported |
| All patients, total | | | | | | | | | | | | |
| Central city(s) | | | | | | | | | | | | |
| Census tract 1 | | | | | | | | | | | | |
| Census tract 2 | | | | | | | | | | | | |
| Census tract 3 | | | | | | | | | | | | |
| Census tract 4 | | | | | | | | | | | | |
| Etc. | | | | | | | | | | | | |
| Suburbs | | | | | | | | | | | | |
| Suburb A, total | | | | | | | | | | | | |
| Census tract 1 | | | | | | | | | | | | |
| Census tract 2 | | | | | | | | | | | | |
| Etc. | | | | | | | | | | | | |
| Suburb B | | | | | | | | | | | | |
| Suburb C | | | | | | | | | | | | |
| Suburb D | | | | | | | | | | | | |
| Etc. | | | | | | | | | | | | |
| Remainder of region | | | | | | | | | | | | |
| RFD 1 | | | | | | | | | | | | |
| RFD 2 | | | | | | | | | | | | |
| RFD 3 | | | | | | | | | | | | |
| Etc. | | | | | | | | | | | | |

Table 26.—Number of Patients, by Place of Residence, Hospital and Type of Accommodation—Cont.

| Patients' place of residence | All hospitals | | | Hospital A | | | Hospital B | | | Etc. | | |
|------------------------------|------------------|-----------------|-----------------|------------------|-----------------|-----------------|------------------|-----------------|-----------------|------------------|-----------------|-----------------|
| | 1- to 4-bed room | Over 4-bed room | Not re-reported | 1- to 4-bed room | Over 4-bed room | Not re-reported | 1- to 4-bed room | Over 4-bed room | Not re-reported | 1- to 4-bed room | Over 4-bed room | Not re-reported |
| Contiguous counties | | | | | | | | | | | | |
| County 1 | | | | | | | | | | | | |
| County 2 | | | | | | | | | | | | |
| County 3 | | | | | | | | | | | | |
| County 4 | | | | | | | | | | | | |
| Etc. | | | | | | | | | | | | |
| Elsewhere in State | | | | | | | | | | | | |
| Out of State | | | | | | | | | | | | |
| Not reported | | | | | | | | | | | | |

Sources:

1. Inpatient information questionnaire, questions A and K.

Questions answered:

1. What is *each hospital's service area* with respect to ward (i.e., low income) patients?
2. Does *each hospital's service area* for such patients differ from that for other patients?

Use:

1. Helps hospitals to understand how neighborhood changes may affect the need for various types of inpatient accommodations.
2. May assist individual hospitals in planning services for low income patients.

Table 27.—Number and Percent of Discharged Patients, by Type of Accommodation and Primary Source of Payment

| Primary source of payment | Total patients | Percent | Number of Patients | | | | | Percent | | | | |
|---------------------------------|----------------|---------|--------------------|------------|------------------|-------------|-----------------|------------|------------|------------------|-------------|-----------------|
| | | | 1-bed room | 2-bed room | 3- to 4-bed room | Over 4 beds | Not re-reported | 1-bed room | 2-bed room | 3- to 4-bed room | Over 4 beds | Not re-reported |
| All patients, total | | 100 | | | | | | | | | | |
| Non-indigent | | 100 | | | | | | | | | | |
| Private pay | | 100 | | | | | | | | | | |
| Blue Cross | | 100 | | | | | | | | | | |
| Commercial insurance | | 100 | | | | | | | | | | |
| Indigent | | 100 | | | | | | | | | | |
| Public welfare agencies | | 100 | | | | | | | | | | |
| Kerr-Mills | | 100 | | | | | | | | | | |
| Private charitable organization | | 100 | | | | | | | | | | |
| Free care | | 100 | | | | | | | | | | |
| Not reported | | 100 | | | | | | | | | | |

Sources:

1. Inpatient information questionnaire, questions K and L.

Questions answered:

1. What is the relationship between ability to pay and type of accommodation?
2. How many patients are indigent for hospital purposes?
3. How many patients rely primarily on insurance to pay their hospital bills?

Use:

1. Helps hospitals to understand how changes in ability to pay and prepayment coverage may affect the need for various types of inpatient accommodations.
2. Shows the extent to which welfare assistance and other assistance is required by patients to pay for hospital expenses.
3. May help to enhance support for areawide planning on the part of third-party payers.

Table 28.—*Number of Patients, by Pay Status,* Hospital and Place of Residence*

| Patients' place of residence | All hospitals | | | Hospital A | | | Hospital B | | | Etc. | | |
|------------------------------|---------------|---------------|-----------------------|------------|---------------|-----------------------|------------|---------------|-----------------------|-------|---------------|-----------------------|
| | Total | Indi- gent | Non- indi- gent | Total | Indi- gent | Non- indi- gent | Total | Indi- gent | Non- indi- gent | Total | Indi- gent | Non- indi- gent |
| All patients, total | | | | | | | | | | | | |
| Central city(s) | | | | | | | | | | | | |
| Census tract 1 | | | | | | | | | | | | |
| Census tract 2 | | | | | | | | | | | | |
| Census tract 3 | | | | | | | | | | | | |
| Census tract 4 | | | | | | | | | | | | |
| Etc. | | | | | | | | | | | | |
| Suburbs | | | | | | | | | | | | |
| Suburb A, total | | | | | | | | | | | | |
| Census tract 1 | | | | | | | | | | | | |
| Census tract 2 | | | | | | | | | | | | |
| Etc. | | | | | | | | | | | | |
| Suburb B | | | | | | | | | | | | |
| Suburb C | | | | | | | | | | | | |
| Suburb D | | | | | | | | | | | | |
| Etc. | | | | | | | | | | | | |
| Remainder of region | | | | | | | | | | | | |
| RFD 1 | | | | | | | | | | | | |
| RFD 2 | | | | | | | | | | | | |
| RFD 3 | | | | | | | | | | | | |
| Etc. | | | | | | | | | | | | |

See footnote at end of table.

Table 28.—Number of Patients, by Pay Status,* Hospital and Place of Residence—Continued

| Patients' place of residence | All hospitals | | | Hospital A | | | Hospital B | | | Etc. | | |
|------------------------------|---------------|---------------|-----------------------|------------|---------------|-----------------------|------------|---------------|-----------------------|-------|---------------|-----------------------|
| | Total | Indi- gent | Non- indi- gent | Total | Indi- gent | Non- indi- gent | Total | Indi- gent | Non- indi- gent | Total | Indi- gent | Non- indi- gent |
| Contiguous counties | | | | | | | | | | | | |
| County 1 | | | | | | | | | | | | |
| County 2 | | | | | | | | | | | | |
| County 3 | | | | | | | | | | | | |
| County 4 | | | | | | | | | | | | |
| Etc. | | | | | | | | | | | | |
| Elsewhere in State | | | | | | | | | | | | |
| Out of State | | | | | | | | | | | | |
| Not reported | | | | | | | | | | | | |

*Indigent—patients whose primary source of payment is welfare, Kerr-Mills, free care or charity. Nonindigent—patients whose primary source of payment is private pay, Blue Cross, or commercial insurance.

Sources:

1. Inpatient information questionnaire, questions A and L.

Questions answered:

1. Where do indigent patients reside?
2. Do all hospitals participate in indigent care?
3. Does each hospital's service area coincide for both indigent and nonindigent patients?
4. Do indigent patients tend to use nearby facilities?

Use:

1. Assists hospitals in changing neighborhoods to realistically assess their future roles.
2. Helps to plan realistically for services to patients unable to pay.

Table 29.—Number of Reported Outpatients, by Place of Residence and Facility

| Patients' place of residence | All facilities | Facility A | Facility B | Facility C | Facility D | Facility E | Facility F | Facility G | Etc. |
|------------------------------|----------------|------------|------------|------------|------------|------------|------------|------------|------|
| All patients, total | | | | | | | | | |
| Central city(s) | | | | | | | | | |
| Census tract 1 | | | | | | | | | |
| Census tract 2 | | | | | | | | | |
| Census tract 3 | | | | | | | | | |
| Census tract 4 | | | | | | | | | |
| Etc. | | | | | | | | | |
| Suburbs | | | | | | | | | |
| Suburb A, total | | | | | | | | | |
| Census tract 1 | | | | | | | | | |
| Census tract 2 | | | | | | | | | |
| Etc. | | | | | | | | | |
| Suburb B | | | | | | | | | |
| Suburb C | | | | | | | | | |
| Suburb D | | | | | | | | | |
| Etc. | | | | | | | | | |
| Remainder of region | | | | | | | | | |
| RFD 1 | | | | | | | | | |
| RFD 2 | | | | | | | | | |
| RFD 3 | | | | | | | | | |
| Contiguous counties | | | | | | | | | |
| County 1 | | | | | | | | | |
| County 2 | | | | | | | | | |
| County 3 | | | | | | | | | |
| County 4 | | | | | | | | | |
| Elsewhere in State | | | | | | | | | |
| Out of State | | | | | | | | | |

Sources:

1. Outpatient information questionnaire, question A.

Questions answered:

1. What is the total volume of outpatient services?
2. What is the contribution of each facility toward meeting total demand?
3. What is each facility's service area for providing outpatient service?

Use:

1. Shows what areas are important to each facility.
2. Shows which facilities are important to each area.
3. Shows whether outpatients tend to reside predominantly in low income areas.
4. Provides basic data which can be useful in developing guides to need for ambulatory facilities.

Table 30.—Number of Reported Outpatients, by Type of Patient, Pay Status and Place of Residence*

| Patient's place of residence | All patients | | | | Emergency | | | | Clinic | | | | Private referred | | | |
|------------------------------|--------------|----------|----------|------|-----------|----------|----------|------|--------|----------|----------|------|------------------|----------|----------|------|
| | Total | Full pay | Part pay | Free | Total | Full pay | Part pay | Free | Total | Full pay | Part pay | Free | Total | Full pay | Part pay | Free |
| All patients, total | | | | | | | | | | | | | | | | |
| Central city(s) | | | | | | | | | | | | | | | | |
| Census tract 1 | | | | | | | | | | | | | | | | |
| Census tract 2 | | | | | | | | | | | | | | | | |
| Census tract 3 | | | | | | | | | | | | | | | | |
| Census tract 4 | | | | | | | | | | | | | | | | |
| Etc. | | | | | | | | | | | | | | | | |
| Suburbs | | | | | | | | | | | | | | | | |
| Suburb A, total | | | | | | | | | | | | | | | | |
| Census tract 1 | | | | | | | | | | | | | | | | |
| Census tract 2 | | | | | | | | | | | | | | | | |
| Etc. | | | | | | | | | | | | | | | | |
| Suburb B | | | | | | | | | | | | | | | | |
| Suburb C | | | | | | | | | | | | | | | | |
| Suburb D | | | | | | | | | | | | | | | | |
| Etc. | | | | | | | | | | | | | | | | |
| Remainder of region | | | | | | | | | | | | | | | | |
| RFD 1 | | | | | | | | | | | | | | | | |
| RFD 2 | | | | | | | | | | | | | | | | |
| RFD 3 | | | | | | | | | | | | | | | | |

See footnote at end of table.

Table 30.—Number of Reported Outpatients, by Type of Patient, Pay Status and Place of Residence*—Continued

| Patient's place of residence | All patients | | | | Emergency | | | | Clinic | | | | Private referred | | | |
|------------------------------|--------------|----------|----------|------|-----------|----------|----------|------|--------|----------|----------|------|------------------|----------|----------|------|
| | Total | Full pay | Part pay | Free | Total | Full pay | Part pay | Free | Total | Full pay | Part pay | Free | Total | Full pay | Part pay | Free |
| Contiguous counties | | | | | | | | | | | | | | | | |
| County 1 | | | | | | | | | | | | | | | | |
| County 2 | | | | | | | | | | | | | | | | |
| County 3 | | | | | | | | | | | | | | | | |
| County 4 | | | | | | | | | | | | | | | | |
| Elsewhere in State | | | | | | | | | | | | | | | | |
| Out of State | | | | | | | | | | | | | | | | |

*Complete 1 copy of this table for each hospital separately.

Sources:

1. Outpatient information questionnaire, questions A, F, and H.

Questions answered:

1. What is each hospital's service area for outpatient and emergency services?
2. Do free and part-pay patients tend to live in the immediate vicinity of the hospital?
3. How many emergency, clinic and private referred patients were there during the survey period?
4. How were patients distributed by pay status during the survey period?

Use:

1. Helps hospitals to plan ambulatory services on a realistic basis by showing them the area served by their outpatient and emergency facilities.
2. Alerts hospitals to possible changes in patient load that may occur as a result of population shifts within the planning region.
3. Helps planners to understand whether ambulatory facilities should be planned primarily in relation to low income groups.

Table 31.—Number of Outpatients, by Type and Disposition of Case

| Type of case | All cases | Admitted | Admission recommended or scheduled | Other | Not reported |
|------------------------------------|-----------|----------|------------------------------------|-------|--------------|
| All outpatient and emergency cases | | | | | |
| All outpatients | | | | | |
| Clinic patients | | | | | |
| Tumor | | | | | |
| Heart | | | | | |
| Orthopedic | | | | | |
| Mental health | | | | | |
| Well baby | | | | | |
| Prenatal | | | | | |
| EENT | | | | | |
| GYN | | | | | |
| Etc. | | | | | |
| Private referred | | | | | |
| Tumor | | | | | |
| Heart | | | | | |
| Orthopedic | | | | | |
| Mental health | | | | | |
| Well baby | | | | | |
| Prenatal | | | | | |
| EENT | | | | | |
| GYN | | | | | |
| Etc. | | | | | |
| Emergency patients | | | | | |
| Type of case not reported | | | | | |

Sources:

1. Outpatient information questionnaire, questions B, F, and G.

Questions answered:

1. To what extent does the outpatient department contribute to inpatient admissions?
2. Do certain types of clinics appear to contribute to the volume of inpatient admissions to a greater extent than others?
3. To what extent do emergency services contribute to inpatient load?
4. How many outpatients are admitted directly, without delay?

Use:

1. Shows the effects of the operation of an outpatient department on inpatient admissions.
2. Assists planning agencies to anticipate possible increases in inpatient load that may result from wider use of ambulatory facilities.

Table 32.—Number of Outpatients, by Age, Race, and Sex*

| Age group | All patients | | | | | Male | | | | | Female | | | | | Sex not reported |
|------------------|--------------|-------|-------|-------|--------------|-------|-------|-------|-------|--------------|--------|-------|-------|-------|--------------|------------------|
| | Total | White | Negro | Other | Not reported | Total | White | Negro | Other | Not reported | Total | White | Negro | Other | Not reported | |
| All ages | | | | | | | | | | | | | | | | |
| Under 15 | | | | | | | | | | | | | | | | |
| 15-44 | | | | | | | | | | | | | | | | |
| 45-64 | | | | | | | | | | | | | | | | |
| 65-74 | | | | | | | | | | | | | | | | |
| 75-84 | | | | | | | | | | | | | | | | |
| 85+ | | | | | | | | | | | | | | | | |
| Age not reported | | | | | | | | | | | | | | | | |

*The same table format may be used to show the number of outpatients by age, race, and sex for each type of clinic, or to show the age, race, and sex characteristics of emergency patients. A separate table should be prepared for each type of clinic and for emergency cases.

Sources:

1. Outpatient information questionnaire, questions C, D, and E.

Questions answered:

1. What are the age, race, and sex characteristics of outpatients?

Use:

1. Assists in determining whether outpatient facilities should be planned in relation to particular population groups.

Table 33.—Number of Outpatients, by Age, Sex and Type of Patient

| Type of case | All ages | | | Under 16 | | | 15-44 | | | 45-64 | | | 65-74 | | | Etc. | | | Age not reported |
|------------------------------------|----------|---|--------------|----------|---|--------------|-------|---|--------------|-------|---|--------------|-------|---|--------------|------|---|--------------|------------------|
| | M | F | Not reported | M | F | Not reported | M | F | Not reported | M | F | Not reported | M | F | Not reported | M | F | Not reported | |
| All outpatient and emergency cases | | | | | | | | | | | | | | | | | | | |
| All outpatients | | | | | | | | | | | | | | | | | | | |
| Clinic patients | | | | | | | | | | | | | | | | | | | |
| Tumor | | | | | | | | | | | | | | | | | | | |
| Heart | | | | | | | | | | | | | | | | | | | |
| Orthopedic | | | | | | | | | | | | | | | | | | | |
| Mental health | | | | | | | | | | | | | | | | | | | |
| Well baby | | | | | | | | | | | | | | | | | | | |
| Prenatal | | | | | | | | | | | | | | | | | | | |
| EENT | | | | | | | | | | | | | | | | | | | |
| GYN | | | | | | | | | | | | | | | | | | | |
| Etc. | | | | | | | | | | | | | | | | | | | |
| Private referred | | | | | | | | | | | | | | | | | | | |
| Tumor | | | | | | | | | | | | | | | | | | | |
| Heart | | | | | | | | | | | | | | | | | | | |
| Orthopedic | | | | | | | | | | | | | | | | | | | |
| Mental health | | | | | | | | | | | | | | | | | | | |
| Well baby | | | | | | | | | | | | | | | | | | | |
| Prenatal | | | | | | | | | | | | | | | | | | | |
| EENT | | | | | | | | | | | | | | | | | | | |
| GYN | | | | | | | | | | | | | | | | | | | |
| Etc. | | | | | | | | | | | | | | | | | | | |
| Emergency patients | | | | | | | | | | | | | | | | | | | |
| Type case not reported | | | | | | | | | | | | | | | | | | | |

Sources:

1. Outpatient information questionnaire, questions B, C, D, and G.

Questions answered:

1. How many patients attended each type of clinic during the survey period?
2. What are the age and sex characteristics of the ambulatory patients treated during the survey period?

Use:

1. Provides an inventory of the major characteristics of ambulatory patients.
2. When compared with summarized annual data, can be used to determine how representative of a full year's operation are data collected in the outpatient information survey.
3. Helps to establish rates of usage of each type of clinic by the population.

Table 34.—Number and Percent of Reported Long-Term Facilities and Beds, by Types of Patients Accepted

| Type of patient | Total reporting facilities | Percent | Total beds reported | Percent | Number of facilities | Number of beds | Percent facilities | Percent beds |
|---------------------|----------------------------|---------|---------------------|---------|----------------------|----------------|--------------------|--------------|
| Male | | 100 | | 100 | | | | |
| Female | | 100 | | 100 | | | | |
| Couples | | 100 | | 100 | | | | |
| White | | 100 | | 100 | | | | |
| Negro | | 100 | | 100 | | | | |
| Oriental | | 100 | | 100 | | | | |
| Other nonwhite | | 100 | | 100 | | | | |
| Age under 20 | | 100 | | 100 | | | | |
| Age 20-65 | | 100 | | 100 | | | | |
| Age over 65 | | 100 | | 100 | | | | |
| Mentally retarded | | 100 | | 100 | | | | |
| Mentally ill | | 100 | | 100 | | | | |
| Senile | | 100 | | 100 | | | | |
| Spastic | | 100 | | 100 | | | | |
| Alcoholic | | 100 | | 100 | | | | |
| Drug addicted | | 100 | | 100 | | | | |
| Diabetic | | 100 | | 100 | | | | |
| Tubercular | | 100 | | 100 | | | | |
| Cancer | | 100 | | 100 | | | | |
| Blind | | 100 | | 100 | | | | |
| Deaf | | 100 | | 100 | | | | |
| Postoperative | | 100 | | 100 | | | | |
| Incontinent (feces) | | 100 | | 100 | | | | |
| Incontinent (urine) | | 100 | | 100 | | | | |

Table 34.—Number and Percent of Reported Long-Term Facilities and Beds, by Types of Patients Accepted—Continued

| Type of patient | Total reporting facilities | Percent | Total beds reported | Percent | Number of facilities | Number of beds | Percent facilities | Percent beds |
|--|----------------------------|---------|---------------------|---------|----------------------|----------------|--------------------|--------------|
| Bedfast | | 100 | | 100 | | | | |
| Ambulatory (unassisted) | | 100 | | 100 | | | | |
| Ambulatory (assisted) | | 100 | | 100 | | | | |
| Confined to wheelchair | | 100 | | 100 | | | | |
| Patients requiring intravenous feeding | | 100 | | 100 | | | | |
| "Noisy" | | 100 | | 100 | | | | |
| Welfare cases | | 100 | | 100 | | | | |

Sources:

1. Long-term care facility information questionnaire, question A.

Questions answered:

1. How many beds are available for each type of patient?

Use:

1. Provides an inventory of long-term facilities and beds.
2. May indicate gaps in the availability of facilities open to particular types of patients.

Table 35.—Number of Reporting Long-Term Facilities With Coordinated Programs, by Type of Coordination and Type of Agreement

| Type of coordination | Total facilities reporting | Percent | Number of hospitals | | | Percent with agreements |
|--|----------------------------|---------|-----------------------|--------------------|-----------------------------|-------------------------|
| | | | Total with agreements | Written agreements | Oral or informal agreements | |
| Consultation | | 100 | | | | |
| Sharing of personnel | | 100 | | | | |
| Hospital trains home's staff | | 100 | | | | |
| Hospital does laboratory work for home | | 100 | | | | |
| Home assists in geriatric training for hospital's staff and/or professional students | | 100 | | | | |
| Hospital provides acute care for home's patients | | 100 | | | | |
| Other | | 100 | | | | |

Sources:

1. Long-term care facility information questionnaire, question B.

Questions answered:

1. What kinds of cooperative arrangements exist between long-term facilities and general hospitals?
2. How many long-term facilities participate in such arrangements?

Use:

1. Indicates to facilities possible steps that can be taken to improve coordination and upgrade quality of care.

Table 36.—Number and Percent of Long-Term Facilities and Beds by Types of Professional Personnel Available

| Type of personnel | Number of facilities | Number of beds | Percent of all long-term facilities | Percent of all long-term beds |
|--------------------------|----------------------|----------------|-------------------------------------|-------------------------------|
| Full time | | | | |
| Physician | | | | |
| Registered nurse | | | | |
| Licensed practical nurse | | | | |
| Dentist | | | | |
| Dietitian | | | | |
| Physical therapist | | | | |
| Occupational therapist | | | | |
| Social worker | | | | |
| Clergyman | | | | |
| Part time | | | | |
| Physician | | | | |
| Registered nurse | | | | |
| Licensed practical nurse | | | | |
| Dentist | | | | |
| Dietitian | | | | |
| Physical therapist | | | | |
| Occupational therapist | | | | |
| Social worker | | | | |
| Clergyman | | | | |
| On call | | | | |
| Physician | | | | |
| Registered nurse | | | | |
| Licensed practical nurse | | | | |
| Dentist | | | | |
| Dietitian | | | | |
| Physical therapist | | | | |
| Occupational therapist | | | | |
| Social worker | | | | |
| Clergyman | | | | |

Sources:

1. Long-term care facility information questionnaire, question C.

Questions answered:

1. What kinds of professional personnel are available for the care of patients in long-term facilities?
2. What proportion of facilities employ the types of professional persons listed?
3. What proportion of long-term beds is located in facilities employing the types of professional persons listed?

Use:

1. Provides some indication of quality of care available to long-term patients.
2. May help to stimulate better staffing.

Table 37.—Current and Projected Number of Long-Term Beds, by Facility

| Long-term beds | All facilities | Facility A | Facility B | Facility C | Etc. | Etc. |
|---|----------------|------------|------------|------------|------|------|
| Existing beds | | | | | | |
| Beds under construction | | | | | | |
| Beds after completion of current construction | | | | | | |
| Additional beds planned next 5 years | | | | | | |
| Total projected beds next 5 years | | | | | | |

Sources:

1. Long-term care facility information questionnaire, question D.

Questions answered:

1. What is the bed capacity of each facility?
2. Which facilities are currently expanding capacity?
3. Which facilities are planning to expand?
4. How many long-term beds are projected for construction over the next 5 years?

Use:

1. Provides an inventory of existing and projected facilities.
2. May be used to determine whether construction plans are consonant with needs.

Table 38.—Number of Patients, by Ambulatory Status and Facility

| Ambulatory status | All facilities | Facility A | Facility B | Facility C | Etc. | Etc. |
|----------------------|----------------|------------|------------|------------|------|------|
| Total patients | | | | | | |
| Bedfast | | | | | | |
| Wheelchair | | | | | | |
| Ambulatory, assisted | | | | | | |
| Fully ambulatory | | | | | | |

Sources:

1. Long-term care facility information questionnaire, question E.

Questions answered:

1. How many patients suffer from each major type of disability?
2. How are patients with various kinds of disabilities distributed in each facility?

Use:

1. Helps to show long- and short-term facilities the need for cooperation in planning restorative services.
2. Helps to pinpoint facilities which care for the most severely disabled patients and where coordinated relationships will be beneficial.

Table 39.—*Number of Long-Term Patients Transferred to and from Hospitals, Number Treated in Infirmary Units, and Number Examined or Treated by a Physician during the Month of _____ 19__, by Facility*

| Patient Category | All Facilities | Facility A | Facility B | Facility C | Etc. | Etc. |
|------------------------------------|----------------|------------|------------|------------|------|------|
| All long-term patients | | | | | | |
| Percent | 100 | 100 | 100 | 100 | 100 | 100 |
| Number transferred to hospital * | | | | | | |
| Percent of total | | | | | | |
| Number transferred from hospital * | | | | | | |
| Percent of total | | | | | | |
| Number treated in infirmary * | | | | | | |
| Percent of total | | | | | | |
| Number examined by physician * | | | | | | |
| Percent of total | | | | | | |

*These categories are not necessarily mutually exclusive.

Sources:

1. Long-term care facility information questionnaire, question E.

Questions answered:

1. What proportion of long-term patients required treatment in an infirmary unit or hospital?
2. How many new long-term patients were transferred from a hospital?
3. How many long-term patients were examined by a physician?

Use:

1. Shows importance of hospitals in providing acute care for long-term patients.
2. Shows the importance of hospitals as a source of admissions.
3. Shows the extent of medical supervision of long-term patients.

Table 40.—*Number of Long-Term Patients, by Age and Sex*

| Age group | All patients | Male | Female |
|-----------|--------------|------|--------|
| Under 15 | | | |
| 15-44 | | | |
| 45-64 | | | |
| 65-74 | | | |
| 75-84 | | | |
| 85+ | | | |

Sources:

1. Long-term care facility information questionnaire, question G.

Questions answered:

1. How many patients are there in each age group?
2. How many male and female patients are there?

Use:

1. Helps to establish what proportion of each age group is currently receiving long-term care.
2. Assists in developing standards of usage to help in determining need.

Appendix III

State Statutes Pertaining to Financing Hospital Construction, Maintenance and Operation

Alabama (citations may be found in *Code of Alabama, Recompiled, 1958*)

204(11)–204(17): Authorizes the creation of “hospital associations” by local governing bodies in one or more contiguous counties of the State. A hospital association may “cooperate” with the State Board of Health for the purpose of constructing, equipping, maintaining and operating a hospital. A hospital association may acquire property by eminent domain and may issue bonds backed by pledges of its revenues. Local governing bodies may appropriate their shares of construction, maintenance and equipment costs to an association hospital.

204(18)–204(30): Authorizes the creation of “county hospital boards” by three or more persons after approval by the county governing body. A hospital board may issue securities and build, equip, enlarge, or improve a hospital and conduct a nurses’ training school within the county.

Constitution, Amendment LXXIV: Provides for a bond issue to finance State matching grants for hospitals, clinics, and health centers.

Constitution, Amendment LXXVI: Authorizes a special tax in all counties except Mobile and Jefferson to equip, operate, and maintain public hospitals, clinics, health centers, nurses’ homes and training facilities conducted by duly designated organizations.

Constitution, Amendment LXXV: Authorizes Marion County to pledge certain revenues to back bonds the proceeds of which are to be used for constructing, equipping, and operating public hospitals and related facilities.

Constitution, Amendment LXX: Authorizes a special tax in Escambia County for acquiring,

constructing, equipping, and operating county, public, or other nonprofit hospitals and health facilities.

Constitution, Amendment LXXII: Same as Amendment LXX except that it applies to all counties except Mobile, Montgomery and Jefferson.

Constitution, Amendment LXXIX: Authorizes Marion County to levy a special tax to acquire, construct, improve, or maintain county or other public hospital facilities within the county.

Arizona (citations may be found in *Arizona Revised Statutes*)

36-1231–36-1248: Authorizes the formation of hospital districts which are empowered to construct and equip, but not to operate hospitals. District hospitals must be operated by nonprofit hospital corporations through leasing arrangements.

California (citations may be found in *California Annotated Codes*)

Vol. 41, Secs. 32000–32940: Authorizes the formation of hospital districts to establish, maintain, and operate hospitals and conduct nurses’ training schools. A hospital district is formed by a favorable vote in an election. It may be composed of incorporated and/or unincorporated territory which need not be contiguous. A district may incur indebtedness and may levy taxes not to exceed 20¢ on each \$100 valuation.

Vol. 39, Sec. 435.3: Authorizes State matching grants for Hill-Burton projects.

Vol. 34, Sec. 25369: Authorizes county supervisors by a four-fifths vote to grant any money

accumulated in a capital outlay fund to a hospital district in which the entire county is included.

Vol. 34, Sec. 25368: Authorizes county supervisors to transfer real property to a hospital district by unanimous vote.

Vol. 35, Sec. 37.654: Authorizes fifth- and sixth-class cities in which a municipal hospital has not been established to construct a hospital and provide for its maintenance and operation by tenants subject to approval in an appropriate election on the question.

Colorado (citations may be found in *Colorado Revised Statutes, 1953*)

66-7-1: Provides for a special tax which may be levied for the benefit of county hospitals open to all residents of the county and "all others falling sick or being injured therein" subject to approval in a special referendum on the question.

66-7-13: Authorizes the boards of county hospitals to rent or lease such hospitals to nonprofit Colorado hospital corporations for any rental and any period deemed proper.

Georgia (citations may be found in *Georgia Code Annotated*)

99-1501: Authorizes the creation of hospital authorities that include within their jurisdictions one or more counties, cities, towns or municipalities. Participating political units and subdivisions may tax for the purpose of constructing, equipping, altering, modernizing, or repairing any hospital authority project, but authorities themselves have no taxing power. They may, however, pledge their revenues as backing for authority bond issues.

99-1601: Authorizes State grants of up to \$500,000 or one-third of the cost of a project to counties, municipalities, combinations of these or to hospital authorities to assist in the construction of public hospitals and public health centers receiving Hill-Burton aid.

Hawaii (citations may be found in *Revised Laws of Hawaii*)

C. 144, Sec. 2(f): Authorizes the counties of Hawaii, Kauai, and Maui to give aid to hospitals.

Idaho (citations may be found in the *Idaho Code*)

39-1354: Authorizes the formation of hospital districts to furnish general hospital and other services to the general public.

31-3501: Authorizes counties to construct hospitals for indigents and others who are "sick, injured or maimed."

31-3504: Authorizes counties to lease county hospitals on such terms and for such periods as they may decide, or to sell such hospitals provided that such lease or sale is approved in a general or special election.

31-3703: Authorizes the sale or leasing of joint city and county hospitals subject to approval in a general or special election.

Illinois (citations may be found in *Illinois Annotated Statutes*)

Vol. 23, Secs. 1251-1273: Authorizes the formation of hospital districts in counties having over 500,000 population. Provides that no other governmental subdivisions of the State may own, operate or control a hospital within the territory of such a hospital district, and requires that when a district goes into operation, it must reimburse other public agencies operating hospitals within the district for their facilities.

Vol. 91, Sec. 125: Establishes a medical center district in the City of Chicago which may issue bonds, construct hospitals and related facilities, exercise zoning power, and sell, lease, or rent property within its boundaries for hospital and related purposes to institutions operated by the State, political subdivisions, and nonprofit and proprietary organizations.

Vol. 24, Secs. 139-160.2: Authorizes a special tax to support nonprofit, nonsectarian hospitals in any town of under 500,000 population which does not operate a municipal hospital.

Vol. 24, Sec. 44-2: Authorizes the diversion to any nonsectarian public hospital of taxes collected for 3 consecutive years by any municipality for the purpose of establishing or purchasing a city hospital.

Vol. 24, Sec. 45-1: Authorizes any city to contribute money for the construction, maintenance and support of any nonsectarian, public hospital located within its limits.

Vol. 34, Sec. 5351-2: Authorizes a special tax to maintain nonsectarian, nonprofit, community hos-

pitals which agree to provide free care equivalent to one-fourth of total patient days. Such a tax is subject to approval in a referendum on the question.

Indiana (citations may be found in *Indiana Statutes Annotated*)

25-3503: Empowers all hospital associations to borrow and issue bonds.

48-7513: Authorizes any city not having a city hospital to levy a tax and appropriate funds for the support of a nonprofit, nonsectarian hospital which meets certain specific requirements regarding the election of members of its governing board.

48-7514: Authorizes counties to appropriate funds for the support of a nonsectarian, nonprofit hospital meeting certain conditions with respect to the election of members of its governing board provided that there is only one hospital in such county.

48-7501—48-7506: Authorizes fourth- and fifth-class cities having no hospital to borrow, tax, and appropriate funds for the purpose of aiding the construction and operation of a hospital by a nonprofit, nonsectarian group.

48-7512: Authorizes cities having a population between 115,000 and 150,000 to tax for the support and maintenance of nonprofit hospitals provided that no city hospital has been established.

22-3211: Authorizes county aid for nonprofit hospitals in fourth-class cities in any county in which there are insufficient hospitals.

25-3701—25-3710: Authorizes certain townships to tax and borrow funds to enlarge and maintain certain existing hospitals.

22-3404—22-3405: Authorizes certain counties to tax and give aid for maintaining buildings and grounds of tuberculosis hospitals.

Iowa (citations may be found in *Iowa Code Annotated*)

37.18(3): Authorizes the construction and equipment of hospitals at public expense, in accordance with prescribed procedures if such hospitals are built as war memorials.

565.8-565.11: Authorizes counties, cities and towns to levy a special tax to maintain a hospital, where such governmental unit has received a gift for the purpose of establishing a hospital and insufficient funds are provided for its maintenance.

Kentucky (citations may be found in *Kentucky Revised Statutes*)

215.190-215.340: Provides for the establishment of tuberculosis sanatorium districts either by initiative and referendum or by the action of the fiscal court or courts of one or more counties. Once such a district is established adequate county appropriations must be made or taxes levied to cover the cost of the erection of buildings and annual operating expenses.

216.080-216.240: Authorizes cities of the second, third, fourth, and fifth class to purchase, establish, erect, acquire, maintain, and operate a municipal hospital governed by an appointed seven-member commission and to issue bonds to finance such activities.

Kansas (citations may be found in *General Statutes of Kansas Annotated*)

80-2133—80-2153: Authorizes cities of the second class located in counties of 50,000 or more population and containing no cities of the first class to join with one or more townships or portions thereof to form a hospital district for the purpose of maintaining, operating, improving, equipping, purchasing, enlarging, constructing, or reconstructing public hospitals and/or nursing homes which are open to all residents of the district.

80-2113—80-2132: Authorizes any city of the third class, subject to a favorable vote on the question, to join with one or more townships or portions thereof to form a hospital district for the maintenance, operation, improvement, equipment, enlargement, construction, or reconstruction of a hospital located within its limits and open to all residents.

Louisiana (citations may be found in *Louisiana Statutes Annotated*)

46.1051-46.1067: Authorizes the formation of hospital service districts by the police juries of one or more parishes to acquire, construct, and maintain hospitals, nurses' homes, and physicians' and dentists' offices. Such districts may levy a tax for such purposes for a period not exceeding 10 years.

Maine (citations may be found in *Revised Statutes of Maine*)

C. 90-A, Sec. 12(IV)A: Authorizes municipalities to raise or appropriate money to support a hospital serving its residents.

Massachusetts (citations may be found in *Annotated Laws of Massachusetts*)

C. 111, Sec. 73: Authorizes any town (as distinct from cities) to appropriate \$1,000 annually to maintain a bed for the care of resident indigent persons.

Michigan (citations may be found in *Michigan Statutes Annotated*)

5.2456(1-11): Provides for the establishment, by two or more municipalities, of hospital authorities for the purpose of constructing, owning, and operating a hospital or hospitals. Such authorities may issue bonds without prior referendum. Special taxes may be levied for the benefit of hospital authorities.

14.1221-14.1229: Authorizes the establishment of medical center commissions in cities of over 500,000 population. A commission may construct governmental hospitals within a defined district, and may assist private, nonprofit hospitals in raising funds from any available source to finance the purchase of land and the operation of institutional buildings within the boundaries of the district.

14.1181: Authorizes township boards to appropriate from unexpended balances in contingency funds, a reasonable amount of funds for the maintenance and support of any hospital. Contributions to building funds for new hospitals are not authorized.

Constitution, Art. VIII, Sec. 11: Authorizes counties to appropriate funds for the construction, maintenance, or assistance of hospitals admitting patients with contagious or infectious diseases. The courts have held that a hospital does not have to limit its patients to contagious or infectious cases in order to qualify for aid.

14.1221-14.1225: Authorizes counties to levy a 2/10 mill tax to construct, maintain, or assist hospitals admitting patients with contagious or infectious diseases. Hospitals do not have to limit their admissions to such cases in order to qualify for assistance.

Minnesota (citations may be found in *Minnesota Statutes Annotated*)

397.11-397.15: Authorizes the establishment of special hospital districts in counties having 55 to 70 beds and provides for the issuance of county bonds for the benefit of such districts.

397.05-397.102: Authorizes two or more contiguous municipalities by resolution of one or more county boards, to form a hospital district. County bonds may be issued for the benefit of such district and taxes levied without limit as to rate or amount.

36.101-36.111: Authorizes the formation of hospital districts in counties having 63 to 70 beds. The county comprising such a district may tax for its benefit, and the municipality in which a district hospital is located may levy a tax in behalf of the district to the extent of twice the taxes levied for the hospital district in territory outside the municipality.

373.053: Authorizes counties, subject to referendum, to construct a hospital as a war memorial building, provided that the cost of construction does not exceed \$250,000.

376.08: Authorizes counties under 30,000 population to appropriate up to \$65,000 per year from general funds to erect, improve, alter, equip, and maintain a hospital in the county. Also authorizes any county to aid nonprofit rehabilitation centers and schools for the education of crippled children and adults.

376.09: Authorizes counties in which there is no county hospital to appropriate up to \$5,000 per year from general revenues to construct and maintain a hospital within the county.

376.06: Authorizes counties to lease county hospital buildings and grounds to responsible hospital associations.

Mississippi (citations may be found in *Mississippi Code of 1942. Annotated, Compiled 1956*)

7146-05: Authorizes State grants up to 50 percent of the cost of construction (exclusive of Federal grants, site cost, and cost of offsite improvements) for the purpose of constructing, reconstructing, remodeling, erecting, and equipping hospitals, nurses' homes, health centers, clinics, diagnostic and treatment centers, rehabilitation centers, nursing homes, and related facil-

ities. Also provides for State grants to build and equip 17 schools of nursing within the State.

7146-13: Authorizes the State Hospital Commission to make grants for use in purchasing, reconstructing, or remodeling existing hospital facilities "when such facilities would become a part of an immediate, expanding program; which program would substantially increase the available hospital or other health facilities in the area."

7129-50—7129-53: Authorizes counties, cities and towns, and other political subdivisions to build, maintain, and operate community hospitals and other health facilities. Governmental units acting pursuant to this Act may cooperate with nonprofit corporations in constructing or operating such facilities, or may contract for their operation.

3374-144: Authorizes municipalities to donate up to \$100 per month to maintain a charity ward or wards in any hospital in the same county. Also authorizes municipalities to donate and furnish lights, power, and water from municipally owned plants to hospitals and other benevolent institutions located within the municipality.

Missouri (citations may be found in *Annotated Missouri Statutes*)

184.290: Authorizes State grants of up to \$10,000 to counties for the purpose of constructing a hospital or wing of a hospital as a memorial to veterans.

Montana (citations may be found in *Revised Codes of Montana, 1947, Annotated*)

69-3018: Authorizes State grants to match Hill-Burton aid on a dollar-for-dollar basis.

16-4301—16-4313: Authorizes the formation of public hospital districts consisting of whole counties or their political subdivisions for the purpose of owning and operating, leasing and operating, maintaining, or aiding in the maintenance of a public hospital within the district. Such hospital must meet specified standards with respect to the care of indigent patients and non-discrimination on account of race, color, or sex. A special county tax is authorized for the benefit of such districts.

16-1032: Authorizes boards of county commissioners to lease county buildings, equipment, furniture, and fixtures for hospital purposes for

periods not exceeding 5 years on such terms as they deem proper.

Nebraska (citations may be found in *Revised Statutes of Nebraska, 1943*)

15-235: Authorizes municipalities between 5,000 and 40,000 population in which a municipal hospital has not been established to contract with a charitable corporation or association for the erection and management of a hospital and provide for appropriate payments.

New Hampshire (citations may be found in *New Hampshire Revised Statutes Annotated*)

31.4(VI): Authorizes towns to vote such sums as they judge necessary to aid hospitals either within their boundaries or in a neighboring town. Such neighboring town does not have to be in New Hampshire to qualify for such aid.

New Jersey (citations may be found in *New Jersey Statutes Annotated*)

44.5-2: Authorizes any municipality not maintaining a municipal hospital to appropriate money for care of indigents from the municipality in county hospitals.

44.5-10: Authorizes a village, borough, or township having no municipally supported hospital to appropriate money to assist any hospital serving residents of the municipality.

44.5-10.2: Authorizes municipalities which have no municipally maintained hospital to appropriate money to build or enlarge private charitable hospitals within the county which meet certain specified eligibility requirements.

44.5-14: Authorizes the board of freeholders of a county having no county-maintained hospital other than the almshouse sick ward to appropriate money for the construction or enlargement of any private, charitable hospital within the county.

44.5-16: Authorizes all counties other than first class to appropriate one-twelfth of one percent of the value of real and personal property for the operation of a charitable hospital in the county. No hospital may receive more than its actual deficit in yearly operating expenses, and no hospital may receive payment at a rate which

exceeds the average cost per patient in any county hospital operated by the county making the appropriation.

44.5-50: Authorizes counties having no county hospital to issue bonds up to \$15,000 to aid any charitable hospital in constructing new buildings or altering, renovating or repairing old ones.

30.9-29: Authorizes a county which has no county hospital permanently maintaining a building or pavilion for communicable diseases other than tuberculosis or mental to appropriate up to \$50,000 annually to any one hospital which does maintain such facilities, or to contract with such hospital for care of the county's communicable disease patients.

New Mexico (citations may be found in *New Mexico Annotated Statutes 1953*)

14-33-1-14-33-13: Authorizes all cities, towns, and villages to build, own, manage, and operate hospitals; to vote bonds for construction; and to levy taxes for operation. They may lease or delegate operation of such hospitals to other persons.

14-33-14-14-33-41: Authorizes municipalities and counties to enter into agreements for construction, maintenance, and operation of joint county and municipal hospitals and, subject to referendum, to issue bonds for such purposes. The board of county commissioners and the governing body of the municipality, acting jointly, may lease the hospital to any person, firm, corporation, or association or to the county or municipality to maintain and operate the hospital.

New York (citations may be found in Vol. 42 *Consolidated Laws of New York Annotated, 1760-1783*)

Creates a special hospital district for the city of Salamanca and specified surrounding towns for the purpose of erecting and operating a new hospital.

North Carolina (citations may be found in *General Statutes of North Carolina*)

131-90-131-116.1: Authorizes the city council of any city of 75,000 or more population by resolution to establish a hospital authority whose bound-

aries are the city and all territory within 10 miles. A hospital authority is a public corporation and has power to repair, conduct, and operate hospitals, provide teaching and schools for medical students, maintain nursing schools, operate isolation wards, and construct hospitals. A district may borrow money, and it may operate its facilities through agents.

131-126.21: Authorizes boards of county commissioners to establish a hospital authority by resolution and grant to it the powers exercised by municipal hospitals under Sec. 131.98.

131-120: Empowers the North Carolina Medical Care Commission, the State Hill-Burton agency, to administer a program of State grants to cities, towns, political subdivisions, and nonprofit hospital organizations to purchase land, construct, reconstruct, remodel, or add to hospital facilities.

23-1801-23-1808: Authorizes the formation of community hospital associations to aid nonsectarian, nonprofit hospitals. Such aid may be granted to only one community hospital in each county. Subject to referendum, the county may levy a special tax, not to exceed 8 mills for 5 years, for the benefit of such hospital.

131-126.30: Authorizes municipalities, subject to referendum, to levy taxes and issue bonds for planning and acquiring, establishing, developing, constructing, enlarging, improving, or equipping any hospital or hospital site. Condemnation powers may be exercised for these purposes. Municipalities may aid other municipalities or nonprofit associations to provide health facilities. Such assistance may be in the form of gifts of real estate, leases, and interest-free loans. Bonds issued to construct, expand, remodel or alter buildings and equipment are deemed to be bonds issued to finance public buildings owned by the municipality.

Ohio (citations may be found in *Ohio Revised Code Annotated*)

513.07-513.18: Authorizes the formation of joint township district hospital boards by two-thirds vote of the township trustees of two or more contiguous townships in any county. Joint township district hospital boards may levy taxes subject to referendum, and may either build and operate a joint township general hospital or may agree with a municipal corporation which will build, or has built, a hospital to participate in building, enlarging, or operating such hospital.

715.14: Authorizes municipal corporations to provide rent and compensation for operation of free public hospitals operated by such municipal corporations or other associations.

513.01-513.02: Authorizes township trustees to levy a tax not exceeding 1 mill to pay for hospital care for resident indigents.

513.05-513.06: Authorizes township trustees to agree with nonprofit groups to build, enlarge, or manage a hospital for such townships. Subject to referendum, bonds may be issued to finance such arrangements.

5705.22: Authorizes special tax above the 10-mill limitation for the purpose of supporting a county hospital.

5705.20: Authorizes a special tax above the 10-mill limitation for support of tuberculosis hospitals maintaining and caring for residents of the county.

749.01: Authorizes municipalities to levy a tax not exceeding 1 mill for the benefit of a nonprofit group which furnishes free care to residents who are unable to pay.

339.14: Authorizes the appointment of a hospital commission by a county board subsequent to a determination that additional hospital facilities are needed in the county. Such a commission must contain at least three public members and one representative of each nonprofit hospital in the county. It may, with the consent of the county commissioners, make leases with individuals or with any charitable Ohio hospital corporation to provide for rental of land, buildings thereafter constructed, furniture, fixtures, and equipment for use as a general hospital or part of a general hospital. Such leases may not be made for periods exceeding 50 years and are subject to renewal. Subject to referendum, bonds may be issued by the board of county commissioners in behalf of the hospital commission for the purpose of financing the construction and equipment of hospital facilities of any kind or character. The county hospital commission has continuing jurisdiction over hospital facilities constructed under this act, except that the lessee corporation solely is responsible for the administration and operation of the leased facilities and the selection of personnel. Leases may be terminated if after an appropriate hearing it is found that the lessee has failed to operate the leased facilities in accordance with the terms of the agreement.

339.09: Authorizes counties to lease county hospital facilities for periods not exceeding 10

years to nonsectarian, nonprofit, Ohio corporations, a majority of whose members reside in the county. Such leases may be terminated where the lessee fails to operate the leased facilities in accordance with the terms of the agreement.

749.35: Authorizes a municipal corporation owning a hospital to lease it for a period not exceeding 10 years for operation by a nonsectarian, nonprofit, Ohio corporation a majority of whose members reside in the county which contains the municipal corporation. These provisions also apply to any municipal hospital in which a joint township hospital district board or a board of county commissioners is participating. In the event that the lessee corporation fails to operate the leased facilities in accordance with the terms of the agreement, the lease may be terminated.

Oklahoma (citations may be found in *Oklahoma Statutes Annotated*)

Title 63, Sec. 329.5: Authorizes counties, cities and towns or combinations of these, subject to referendum, to issue bonds for the purpose of financing construction or renovation of hospitals and related facilities such as health centers and tuberculosis, mental and chronic units.

Oregon (citations may be found in *Oregon Revised Statutes*)

441.195-441.410: Authorizes the formation of hospital districts which may borrow, subject to referendum, and tax for the purpose of constructing hospitals.

Pennsylvania (citations may be found in *Pennsylvania Statutes Annotated*)

16, *Sec. 2131:* Authorizes a board of county commissioners to appropriate up to \$10 per week to organizations chartered to maintain a tuberculosis sanatorium for each indigent resident of the county cared for therein.

16, *Sec. 2130:* Authorizes counties to appropriate funds to support any charitable hospital or tuberculosis sanatorium in the State which extends treatment and medical attention to their residents.

16, Sec. 12141: Authorizes the commissioners of third-class counties with approval of the Court of Common Pleas to make appropriations to construct and equip buildings and wings for isolation and treatment of contagious diseases in Class A, nonsectarian, nonprofit hospitals which provide free care to the indigent residing in their zones of influence.

16, Sec. 5330: Authorizes the commissioners of second-class counties to appropriate money to support any charitable hospital or tuberculosis sanatorium in the State which extends treatment and medical attention to the residents of such county.

53, Sec. 39505: Authorizes the councils of third-class cities to make appropriations to support or assist hospitals within or near the city.

16, Sec. 2378: Authorizes single counties or two or more counties jointly to enter into an agreement with one or more nonsectarian, nonprofit, general hospitals within the county or counties, or contiguous counties and to appropriate county money to such hospital or hospitals to construct and equip a building, wing or unit for isolation and treatment of contagious diseases. Similar arrangements between counties and municipalities are also authorized.

**Rhode Island (citations may be found in
General Laws of Rhode Island Annotated)**

40-3-14: Authorizes the State legislature to appropriate sums to partially reimburse voluntary general hospitals for care of indigent patients.

South Carolina (citations may be found in *Code of Laws of South Carolina*)

32-863: Authorizes a municipal council to levy a tax to pay the deficit of a municipal hospital.

32-841.2 Authorizes any town having between 1,000 and 5,000 population, subject to referendum, to levy taxes and issue bonds for the purpose of building a hospital.

32-802-32-806: Authorizes a town, city, or county, subject to referendum, to issue bonds in an amount not to exceed the cost of construction to finance the construction of a hospital or a tuberculosis camp.

South Dakota (citations may be found in *South Dakota Code of 1939*)

27.1908: Authorizes counties having no county hospital, in lieu of building one, to establish one

or more wards in private hospitals either within or outside the county and to levy a tax for the establishment of such wards.

27.1907: Authorizes a board of county commissioners, in lieu of maintaining and operating a county hospital, to lease such hospitals to responsible societies or corporations.

Tennessee (citations may be found in *Tennessee Code Annotated*)

1211: Authorizes \$3,000,000 annual appropriation for State matching grants to hospitals receiving assistance under the Hill-Burton Act.

1401-1402: Authorizes cities and counties, either separately or together, to make contracts guaranteeing payment of the expense of maintaining a hospital for a period of 5 years with any person who will defray the expenses of building and equipping a hospital within such city or county for its use.

1404: Authorizes any county or incorporated municipality to contribute property or money to nonprofit general welfare corporations engaged in acquiring, erecting, building, constructing, improving, maintaining, operating, expanding, or repairing any hospital within the State which serves the residents of such county or municipality without regard to race, creed, or color.

Texas (citations may be found in *Texas Annotated Civil Statutes*)

Constitution, Art. 9, Sec. 4: Authorizes Galveston County and other counties having a population of 190,000 or more to form countywide hospital districts for the purpose of furnishing medical and hospital care for the indigent and needy. Such a district may exercise taxing power subject to the approval of the property taxpaying voters of the county.

4437e: Authorizes a city, by ordinance, to create a hospital authority encompassing all its territory. Such authorities do not have the power to tax, but may issue revenue bonds secured by a pledge of the net revenues to be derived from the operation of a hospital or hospitals and other revenues resulting from the ownership of hospital properties.

44940: Authorizes the Commissioners Court of a county of 75,000 or less population and containing property with a minimum assessed valuation of \$25,000,000 to form a public hospital district.

Subject to a favorable vote in an election on the question, such district may levy taxes and issue bonds. It may also lease existing hospital buildings for its own use.

4494q-4494q3: Authorizes the formation of special hospital districts in Lamar, Jefferson, Hidalgo, and Comanche Counties for the purpose of establishing hospitals for the care of the indigent and needy.

4437: Authorizes a city of 10,000 or more population in which a fund of \$50,000 or more has been left or may be left for the purpose of establishing and maintaining a hospital, either itself or together with the county in which it is located, to appropriate such sums as the appropriate governing body or bodies deem sufficient for the care of indigent persons.

44941: Authorizes the Commissioners Court of any county to lease county hospitals, provided that on petition of 50 or more taxpaying voters such hospital may not be leased for more than 5 years unless the proposition to lease is sustained by a majority vote in a referendum on the subject.

4437c: Authorizes the Commissioners Court of a county having a population of 38,000 to 39,000 according to the 1920 census to lease county hospitals on conditions satisfactory to both the Commissioners and the lessee.

Utah (citations may be found in *Utah Code Annotated*, 1953)

17-5-45: Authorizes a county or counties to erect, repair, rebuild, and furnish a hospital and join with cities and towns in the construction, ownership, and operation of hospitals.

10-8-90-10-8-91: Authorizes third-class cities and towns to build, own, and maintain hospitals, either singly or jointly, and to levy a tax for the purpose of building such hospitals.

Vermont (citations may be found in *Vermont Statutes Annotated*)

T. 18, Sec. 2105: Authorizes the State to operate a rehabilitation center through a contract with a general hospital and to help to construct any extra needed facilities in the hospital.

T. 32, Sec. 2601: Authorizes a town or an incorporated village to build and support a nonsectarian hospital in the same county, in an adjoining

county, or in an adjoining county in a neighboring State.

T. 32, Sec. 2602: Authorizes a town to appropriate up to \$700 annually or \$5,000 for a permanent endowment of a free bed or beds for indigent residents.

T. 32, Sec. 2606: Authorizes a city whose charter provides that a board or body other than the legal voters assembled in a city meeting may assess taxes and appropriate money, to make assessments and support a hospital in that city.

Virginia (citations may be found in *Code of Virginia*, 1950)

32-212-32-275: Authorizes a city, upon making a finding that there is a need for additional hospital facilities, to establish a hospital authority by resolution of the city council or other governing body. Cities may make appropriations for improvement, maintenance, or operation of any public hospital or hospital project constructed, operated, or maintained by an authority, and may lease, sell, or convey property to an authority for no consideration or for nominal consideration. Existing nonprofit, charitable hospitals may be included within the "hospital project or projects of the authority." Authorities may issue bonds payable exclusively from the income and revenues of the project(s) constructed and from the proceeds of Federal grants.

32-276: Authorizes a county, city or town, singly or jointly, to establish a "hospital or health center commission" by resolution of their governing bodies after making a finding that there is a need for a hospital or health center. Such a commission may acquire property and acquire, establish, construct, enlarge, improve, maintain, equip, and operate any hospital or health center and any other facilities and services for the care of sick persons. They may issue bonds payable only from the revenues and receipts of the facilities for the acquisition, establishment, or construction of which the bonds were issued.

32-134: Authorizes counties, cities, and towns, separately or jointly, to appropriate funds for the erection, construction, maintenance, and operation of hospitals and health centers as a memorial to veterans. Such funds may be appropriated for existing hospitals and health centers. Facilities receiving such funds must be entirely or partially devoted to charitable purposes.

32-184.1: Authorizes the governing bodies of counties to appropriate money and to make other gifts of real or personal property to be used in the construction or operation, or both, of charitable, nonprofit hospitals.

15-16: Authorizes cities, counties, and towns to make appropriations of public funds or real or personal property to any charitable institution located within their boundaries which is not controlled in whole or in part by any church or sectarian society.

Washington (citations may be found in *Revised Code of Washington*)

70.44: Authorizes the formation of "public hospital districts" consisting of contiguous territory on one or more counties or portions thereof for the purpose of purchasing, constructing, leasing, maintaining, operating, and developing hospitals. Subject to referendum, such districts may levy taxes and issue bonds.

70.30.010-70.30.160: Authorizes counties to use county moneys, levy taxes, and issue bonds to procure a site, construct, equip, and maintain a county tuberculosis hospital.

70.34.010-70.34.190: Authorizes counties to use county moneys, levy taxes, and issue bonds to procure a site, construct, equip, and maintain joint county tuberculosis sanitarium, provided that if this is done, county almshouses may not be used for care of tuberculosis patients.

Wisconsin (citations may be found in *Wisconsin Statutes Annotated*)

66.47: Authorizes counties, together with cities or villages which are wholly or partly within the county, to jointly construct or otherwise acquire, equip, furnish, operate, and maintain a county-city, general hospital.

Wyoming (citations may be found in *Wyoming Statutes, 1957, Annotated*)

35-114-35-136: Authorizes the formation of hospital districts for the purpose of constructing and operating general and tuberculosis hospitals, laboratories, nurses' homes, nurses training facilities, and other related facilities. Districts may issue bonds, and the county or counties in which all or part of a district is located must levy a tax annually for the benefit of the district for its proportionate share of the district's expenses.

38-315-18-322: Authorizes a county to issue bonds and levy taxes for the purpose of building or equipping a county hospital open to both indigents and nonindigents after certain specified initial sums have been raised or donated for this purpose.

18-323: Authorizes a board of trustees of a county memorial hospital, with the consent of the board of county commissioners, to lease such hospital for operation by any person, group, association or corporation, provided for indigent residents of the county. Provision is made for the county to reimburse the operator or lessee of the facility for such free care at agreed-upon rates.

Appendix IV

Metropolitan Area Hospital Surveys

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Appendix V

Areawide Planning Councils for Hospitals and Related Health Facilities, as of July 1963

Staffed Hospital Planning Associations

- Birmingham Area Health Facilities Planning Association,
Care of Coordinating Council,
309 North 23d Street,
Birmingham 3, Ala.
- Charleston Studies Foundation, Inc.,
1523 Kanawaha Valley Building,
300 Capitol Street,
Charleston, W. Va.
- Cleveland Joint Hospital Committee
Care of Welfare Federation of Greater Cleveland,
1001 Huron Road,
Cleveland 5, Ohio.
- Community Chest and Council,
2400 Reading Road,
Cincinnati 2, Ohio.
- Health and Hospital Council of Metropolitan
Savannah, Inc.,
Care of Joseph H. Harrison, Secretary-Treasurer,
22 Bull Street,
Savannah, Ga.
- Health Facilities Planning Council of Hawaii,
Suite 820, Ala Moana Building,
1441 Kapiolani Boulevard,
Honolulu 14, Hawaii.
- Hospital and Health Council of Newark and
Vicinity,
45 Branford Place,
Newark 2, N.J.
- Hospital Planning Association of Allegheny
County,
1046 Union Trust Building,
Pittsburgh 19, Pa.
- Hospital Planning Association of Greater Toledo,
2243 Ashland Avenue,
Toledo 10, Ohio.
- Hospital Planning Council for Metropolitan Chi-
cago, Inc.,
79 West Monroe Street,
Chicago 3, Ill.
- Hospital Planning Council for the Metropolitan
Portland Area,
1133 S.W. Market Street,
Portland, Oreg.
- Hospital Review and Planning Council of Central
New York,
407 South State Street,
Syracuse 2, N.Y.
- Hospital Review and Planning Council of Southern
New York,
3 East 54th Street,
New York 22, N.Y.
- Hospital Review and Planning Council of Western
New York, Inc.,
235 North Street,
Buffalo 1, N.Y.
- Hospital Survey Committee,
Suburban Station Building,
Philadelphia, Pa.
- Kansas Health Facilities Information Service,
1133 Topeka Boulevard,
Topeka, Kans.

Metropolitan St. Louis Hospital Planning Commission, Inc.,
407 North Eighth Street,
St. Louis 1, Mo.

Regional Hospital Review and Planning Council
of Northeastern New York,
90 State Street,
Albany 7, N.Y.

Metropolitan Washington Health Facilities Planning Council, Inc.,
704 17th Street NW.,
Washington 6, D.C.

St. Paul Hospital Planning Council,
300 Wilder Building,
Fifth and Washington Streets,
St. Paul 2, Minn.

Hospital Councils Engaged in Planning and Membership Council Functions

The Columbus Hospital Federation,
1666 East Broad Street,
Columbus 16, Ohio.

Hospital Council of Southern California,
4747 Sunset Boulevard,
Los Angeles 27, Calif.

Greater Detroit Area Hospital Council, Inc.,
1084 Penobscot Building,
Detroit 26, Mich.

Kansas City Area Hospital Association,
3637 Broadway, Box 169,
Kansas City 41, Mo.

Rochester Regional Hospital Council,
154 East Avenue,
Rochester 4, N.Y.

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"Medical School Facilities—Planning Considerations and Architectural Guide," Prepared by the Public Health Service in cooperation with the Ad Hoc Committee on Medical School Architecture of the Association of American Medical Colleges and the American Medical Association. Public Health Service Publication No. 875. October 1961. 185 pp. \$1.00.

"Areawide Planning of Facilities for Long-Term Treatment and Care," Report of the Joint Committee of the American Hospital Association and the Public Health Service. Public Health Service

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"Areawide Planning of Facilities for Tuberculosis Services," Report of the Joint Committee of the National Tuberculosis Association and the Public Health Service. (In process.)

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